

The Relationship Between Client Participation in The
Targeted Assessment Program And
Child Welfare Outcomes

Michelle Baize, Tonya Blandford, Lisa Bosley,
Brandon Harley, Kim Osborne, and Helen Young
University of Louisville

Abstract

The Targeted Assessment Program has been described as a powerful example of high performance collaboration between a state and a university, which has resulted in progressively innovative solutions to the challenges of serving the hard to serve clients of Kentucky's public assistance and child welfare system. Through a contract with the Kentucky Cabinet for Health and Family Services and the University of Kentucky Institute on Women and Substance Abuse, a division of the Center on Drug and Alcohol Research, the Targeted Assessment Program is currently working in 20 Kentucky counties located in welfare offices.

The Relationship Between Client Participation in The Targeted Assessment Program and Child Protection Services

Introduction

The Targeted Assessment Program (TAP) is an innovative approach to service delivery utilized by the Cabinet for Health and Family Services, Department for Community Based Services (DCBS) to identify and address barriers to self-sufficiency and safety in client families. The program, developed through contract with DCBS and the University of Kentucky Institute on Women and Substance Abuse and the Center on Drug and Alcohol Research, utilizes human services professionals to assess and provide follow-up services for DCBS clients in the areas of substance abuse, domestic violence, mental health and learning disabilities. TAP is designed to hire and place professionally trained full-time staff on site at DCBS offices to better coordination and collaboration of services. To be eligible for TAP services clients must meet one of three criteria: (1) client must be K-TAP or TANF eligible, (2) clients must be employment retention recipient, and (3) client must be a DCBS client working with Protection and Permanency, and if the child is no longer home, a reunification plan must be in place. The major job responsibilities of TAP professionals are (1) screening and assessment for the barrier issues, (2) inter/intra agency collaboration, consultation and training, (3) reporting by entering client and program activity data into TAP database, and (4) submit written reports to DCBS management or case managers. Through provision of TAP services DCBS client families may anticipate better and more appropriate services to cope with barrier issues that prevent stability and wellbeing of their respective families. In turn,

fewer acts of maltreatment and lesser need for child protective services may be expected in the future.

Purpose of Study

The purpose of this research is to determine if clients who receive TAP services have their cases closed sooner and have less referral recidivism than those clients who did not receive TAP.

Data will be examined from case files of clients who were recipients of TANF through the CHFS, had an open case with protection and permanency and were accessing TAP services. Data will be examined from an equal number of non-TAP recipient case files. Data examined will include demographics as well as qualitative and quantitative information that will either substantiate or refute the effectiveness of the TAP program in decreasing the amount of time the client case is active with the CHFS and referral recidivism. Identification of strengths and weaknesses of TAP will increase the effectiveness of the program as it continues to develop and address the many needs of the hard to serve population and assist in the direction needed for future research.

Literature Review

TANF Initiatives

In 1996, the federal government passed the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). PRWORA replaced the former federal entitlement program, Aid to Families with Dependent Children (AFDC), the long-standing entitlement program for single mothers. Through this piece of legislation, cash assistance to mothers and children was now called Temporary Assistance to Needy

Families (TANF) and was administered through block grants to individual states. The overall goal of TANF was to promote economic self-sufficiency and reduce dependency on government programs. TANF legislation required that cash assistance to families in need be limited to a lifetime benefit of 60 months. Emphasis was placed on providing education and training so that individuals could leave the welfare roll and enter into the work force (Iverson, 2000; Kalil, 2002; Seefeldt, and Wang, 2002; Lens, 2002; Ridizi, 2004).

TANF legislation was successful in reducing the welfare caseload, however, it did not adequately address the needs of individuals who were unable to transition successfully into employment. Those individuals described as “hard to serve” were most often individuals who suffered the effects of mental illness, domestic violence, substance abuse, and learning disabilities (Taylor and Barusch, 2004). PRWORA legislation did permit states to exempt 20% of their caseloads from the time limit restrictions and also provided states some latitude in transferring block grant monies for the purpose of establishing programs for “hard to serve” recipients (Lee and Curran, 2003).

As stated in the introduction, through a contract with the Cabinet for Health and Family Services and the University of Kentucky Institute on Women and Substance Abuse, Kentucky implemented the Targeted Assessment Project (TAP) in 1999. The goal of the TAP program is to “target” barriers to self-sufficiency and safety among CHFS clients. The remainder of this literature review will focus on some of the common challenges that all states face in addressing the needs of the “hard to serve” and some of the programs that have been developed by other states in the wake of TANF legislation.

A common theme found in the literature is the difficulty that many states experience in accurately identifying individuals who suffer the effects of substance abuse, domestic violence, and mental health problems. This difficulty is complicated by a number of factors including, denial by the client, fear that disclosure will lead to protective service involvement, fear of physical harm in the case of domestic violence, and inadequate training of the service provider in the area of substance abuse, mental health and domestic violence (East, 1999; Kurz, 1998; Postmus, 2004). Lack of identification or improper identification of “hard to serve clients” is of considerable consequence, not only to the individuals in need of service, but also to the states that administer TANF grants. Improper identification and assessment of vulnerable clients could lead to an increase in social problems such as homelessness, and an increase in the number of families becoming involved with child protective services due to issues of child neglect (Postmus, 2004, Taylor and Barusch, 2004, Romero and Chavkin, 2000).

A review of the literature suggests that most states have adopted some type of policy to address the needs of hard to serve clients under TANF legislation. At a minimum most states have developed a screening process to identify the most significant barriers to self-sufficiency (Brown, n.d.). However, based upon a review of the literature, it would appear that there are considerable differences in how each state addresses the needs of the hard to serve. While many states provide comprehensive assessments like the TAP program, often these services are contracted through a memorandum of agreement with another state agency or private organization (Brown, n.d.; U.S. Department of Health and Human Services, 1999).

Kentucky's TAP program appears unique in that assessors are co-housed in local child welfare agencies and pre-treatment, referral, and after care services are provided in one setting by one assessor. The TAP program is further distinguished due to the fact that referrals are accepted from the Division of Protection and Permanency as well as the Division of Family Support (K. Dotson, personal communication, October 7, 2004).

In 1999, the National Center on Addiction and Substance Abuse at Columbia University (CASA) in collaboration with the American Public Human Services Association (APHSA) completed a two-year study on the nation's response to hard to serve clients. In particular, the study focused on the nation's response to substance abuse in welfare reform. In this study, 51 states were surveyed and five states were studied extensively. This study pointed out that each of the states showed promising outcomes by at least identifying vulnerable recipients, and making referrals for appropriate assessment and treatment (American Public Human Services Association (APHSA), 1999).

In North Carolina, the issue of substance abuse and hard to serve clients was addressed by the state employing 46 full-time and 15 part-time Qualified Substance Abuse Professionals (QSAP) in every county division of Social Services. Similar to what is occurring in the TAP program, the QSAP's provide screening, assessment, treatment planning, and aftercare coordination for participants with substance abuse problems (APHSA, 1999).

In Illinois, the Department for Human Services (DHS) developed a program to train 3,000 DHS workers. The workers were trained to use screening tools such as the CAGE assessment to identify substance abuse among TANF recipients. They were also

educated to refer those individuals identified for assessment to appropriate treatment providers (APHSA, 1999).

The state of Maryland implemented a program in which managed health care and county welfare offices worked in collaboration to provide services to individuals with substance abuse problems. The Maryland state legislature mandated the Medicaid managed health care system to provide coverage for substance abuse assessment and treatment for welfare recipients and also allocated additional funding to expand treatment capacity (APHSA, 1999).

Oregon took the approach of developing a strong commitment among community partners by allowing and providing support for the community to develop and implement programs for substance abusing TANF participants. A partnership was forged in which comprehensive services were provided to move participants into employment while simultaneously addressing the specific needs of those individuals with substance abuse problems (APHSA, 1999).

Perhaps the program that most closely resembles the Kentucky TAP program is one developed by the state of Nevada. Like the TAP program, Nevada focuses on multiple barriers to self-sufficiency. Nevada's program places 30 social workers and two supervisors into the 19 district welfare offices. In addition to screening for substance abuse, the Nevada program also focuses on mental health and domestic violence issues. Through this program, vulnerable TANF participants can receive substance abuse and psychological assessments, treatment referrals, case management, home visits and supports from multi-disciplinary teams (APHSA, 1999).

The research suggests that the needs of “hard to serve” recipients are best met when full-time, on-site assessors are co-located within the welfare department. This approach has resulted in an increase in referrals for assessment and treatment, and has also increased the participation rate of “hard to serve” recipients (Jacobi, Hendrickson, and Wallace, 2002). One of the issues that has been identified as a barrier to client participation in the wake of welfare reform is transportation (Harbaugh and Smith, 1998). Research indicates that co-housing an assessor within the welfare agencies has helped to reduce the impact of the transportation barrier. Co-housing treatment providers and those who administer welfare assistance, has led to a great understanding of the problems encountered by the “hard to serve”. Furthermore, it has promoted a collaborative effort between treatment providers and child welfare caseworkers to move clients to self-sufficiency (Jacobi, et al. 2002).

Substance Abuse

Child maltreatment is a national problem that is prevalent throughout our society. Child maltreatment crosses all cultural and socioeconomic boundaries. In the year 2000, three million referrals concerning the welfare of approximately five million children were made to various Child Protective Services (CPS) agencies throughout the United States. Approximately 62 % of the calls made to these CPS agencies were accepted for investigation. Out of that number, approximately 32% resulted in a finding that a child was a victim of maltreatment, or at risk for maltreatment (United States Department of Health and Human Services: National Clearinghouse on Child Abuse and Neglect Information, 2002).

As cited in Buchanan (1996) the 1974 Child Abuse Prevention and Treatment Act defines child abuse and neglect as:

The physical and mental injury, sexual abuse, negligent treatment, or maltreatment of a child under the age of 18 by a person who is responsible for the child's welfare under circumstances which indicate that the child's health or welfare is harmed or threatened thereby. (p.7)

Of particular concern to the child welfare system is the impact that parental substance abuse has on child maltreatment (Chaffin, Kelleher & Hollenberg, 1996; Curtis & McCullough, 1993; Dore, Doris & Wright, 1995; Famularo, Kinscherff & Fenton, 1992; Kelleher, Chaffin, Hollenburg & Fischer, 1994; Merrick, 1993; Rittner & Dozier, 2000; Sagatun-Edwards, Saylor & Shiffett, 1995; Walsh, MacMillan & Jamieson, 2003). The relationship of child maltreatment or risk of maltreatment and parental substance abuse is a subject that has been the source of a good deal of research. The literature reveals that there are some inconsistencies in the data regarding the prevalence rates of substance abuse in child maltreatment cases. According to the United States Department of Health and Human Services: National Clearinghouse on Child Abuse and Neglect (2002), approximately six million children in the United States live with at least one parent who abuses alcohol or other drugs. Another study indicates that between one-third and two-thirds of child maltreatment cases involve substance abuse (United States Department of Health and Human Services: Children's Bureau, 1999). Research by Curtis and McCullough (1993) reported findings of a 1991 survey indicating that 36.8% of the children served by public agencies were affected by problems associated with caregiver substance abuse. Merrick (1993) noted that alcohol and other substances were

involved in 64% of the cases going before the New York City Family Court for child abuse and neglect. Walsh et al. (2003) conducted a retrospective study of adult victims of childhood physical and sexual abuse and the role that substance abuse played in the maltreatment. The rates of physical and sexual abuse were significantly higher, with a more than two-fold increased risk, among subjects reporting parental substance abuse histories. One of the highest relationships between child maltreatment and substance abuse in a particular setting was presented by Sagatun-Edwards et al. (1995) who concluded that 70 % of their court referred sample of child abusers were actively using substances. Chaffin et al. (1996) present a much more conservative figure of the relationship between substance abuse and child maltreatment. Their national representative sample concluded that substance abuse was only present in 21% of neglect cases and 15.1 % of physical abuse cases. Although the statistics vary, the research cited from public reports as well as independent research reveals there is a significant connection between parental substance abuse and child maltreatment.

The literature indicates that when a child has suffered abuse or neglect by a substance abusing caregiver, the effects of the maltreatment are far-reaching and pervasive. The United States Department of Health and Human Services: Children's Bureau (1999) reports that maltreated children of substance abusing parents are more likely to have poorer physical, intellectual, social, and emotional outcomes. Another result of parental substance abuse toward children is the risk these children are at to abuse substances themselves (Besinger, Garland, Litrownik & Landsverk, 1999). An Additional theme in the literature is the consequences for infants who are prenatally exposed to drugs and alcohol. These infants may eventually develop serious and long lasting effects

from being prenatally exposed to substance abuse. Children who were prenatally exposed to drugs have higher rates of depression, anxiety, aggressive behavior, thought problems, distractibility and permanent developmental delays (Brindis, Berkowitz & Clayson, 1997; Chasnoff, 1998; McAlpine, Marshall & Doran, 2001). A study of 204 infants and toddlers placed in family foster care was conducted by McNichol (1999). Of these children, the ones with prenatal exposure to illegal drugs were found to have more special needs in physical and caregiving areas compared to infants who had not been exposed prenatally to illegal substances.

Research indicates that although most child welfare professionals recognize the relationship between substance abuse and child maltreatment, the actual numbers of child abusers who misuse substances is difficult to establish because not all families investigated by CPS agencies are thoroughly screened for substance abuse (Akin & Gregoire, 1997; Ritner & Dozier, 2000; Semidei, Radel, & Nolan, 2001). Because substance abuse has permeated families involved with CPS agencies so rapidly, the training of child welfare workers in this area has not kept pace with the demand. This issue is made even more difficult by the natural tendency of most substance abusers to minimize or even conceal alcohol and drug problems (Gustavsson, 1991; Ritner & Dozier, 2000; Thompson, 1990). Thorough and intensive training of child protection workers in areas of recognizing, intervening and assessing substance abuse of caregivers could help reduce the number of children who are maltreated.

It is important to study the issue of substance abuse and child maltreatment due to the massive numbers of children residing in out of home care as a result of parental substance abuse. According to information from the March, 2004 Adoption and Foster

Care Analysis and Reporting System Report, there were 532,000 children placed in out of home care in the United States in the 2002 fiscal year (United States Department of Health and Human Services: National Adoption Information Clearinghouse, 2004). Further impacting children in out of home care was the passing of the Adoption and Safe Families Act (ASFA) of 1997, in which time-limited reunification services were mandated for all children placed in out of home care. ASFA legislation directed states to begin the process of termination of parental rights by filing a petition with the courts if a child had been in foster care for 15 of the last 22 months (McAlpine et al. 2001). Due to this legislation, it became imperative that families overcome the problems associated with the removal of their children in an expedient manner.

In terms of substance abuse, one of the barriers associated with ASFA time frames and reunification centers around the length of time it takes for a substance abusing individual to engage in recovery (Karoll & Poertner, 2002; McAlpine, et al. 2001; Semidei, et al. 2001). Karoll and Poertner (2002) point out that a common argument against time limited reunification is that it takes longer for individuals affected by substance abuse issues to engage in active recovery than is permitted by the law. They posit that the process of overcoming addiction along with acquiring the skills necessary to effectively parent is a formidable, overwhelming task. In their study of judges, private child welfare caseworkers and substance abuse counselors, these researchers found that the shortened time span in which substance abusing parents have to demonstrate reasonable progress has negatively affected the reunification process. Semidei et al. (2001) found that the push to move children into safe and permanent homes poses a significant problem for families with substance abuse problems. McAlpine et al. (2001)

also emphasized the problems associated with time limited reunification mandates when providing services to substance abusing families. In their study of combining child welfare and substance abuse services, these researchers found that children of parents with substance abuse problems remain in out-of-home care longer than other children, primarily due to the time required to treat the complex nature of substance abusing families. McAlpine et al. (2001) also concluded that in order to improve the success rate of reunifying substance abusing parents with their children, child welfare workers and substance addiction providers must work collaboratively to address the complex needs of substance abusing families.

The literature reviewed reveals that it is evident that substance abuse plays a major role in child abuse and neglect. The effects of this maltreatment can have a major impact throughout the life of the maltreated child. As a result of the abuse or neglect due to parental substance abuse, many children are placed in out-of-home care settings. Due to ASFA mandates, many parents who are substance abusers find it difficult to overcome their issues in a timely enough fashion for their children to return home. Therefore, it would appear that the issue of substance abuse is a barrier to successful reunification outcomes. Based upon the articles reviewed, it would appear that further research is needed in regard to the obstacles that substance abusing families and service providers face in meeting time frames set forth by current legislation for reunification to occur. It would also be helpful to examine how factors such as duration and frequency of substance use among substance abusing families influences reunification outcomes.

Mental Illness

“Child maltreatment is an urgent public health problem, especially for America’s youngest citizens” (Dodge, Berlin, Epstein, Spitz-Roth, et al. 2004, p.2). Child maltreatment can be broken into four main categories: physical abuse, sexual abuse, neglect, and emotional/psychological abuse. Physical abuse is defined as any non-accidental physical injury caused by the child’s parent or caretaker. It may include burning, biting, shaking, kicking, and punching. Neglect involves the inability to meet the basic needs of a child, such as food, clothing, shelter, medical care, and supervision. Neglect also includes the caregiver’s unwillingness or inability to meet the emotional needs of the child. This is more evident in infants when they do not receive the nurturance and bonding they need to develop on target. Sexual abuse includes any contacts or interaction between a child and an adult in which the child is being used for sexual stimulation of the perpetrator or another person. This includes fondling, sexual exploitation, sexual comments, and intercourse. Emotional/psychological abuse consists of blaming, scapegoating, belittling, humiliation, terrorizing, and rejecting the child (Malekpour, 2004).

The Department of Health and Human Services revealed in its most recent statistics that almost one million children were victims of abuse and neglect annually. “Of these victims 56% suffered neglect, 25% physical abuse, 13% sexual abuse, and some were victims of more than one type. In 41 states that reported fatalities, 967 children died because of abuse or neglect, and three quarters of them were under the age of three” (Mulryan, Cathers, & Fagin, 2000, p.1). According to Malekpour (2004) “the U.S. Advisory Board on Child Abuse and Neglect (1995) stresses that maltreatment has

become a leading cause of death among young children, stating that 2,000 die every year and 140,000 are seriously injured” (2004, p. 2). Although these facts and numbers are appalling, many respected authorities on this subject believe that since the abuse occurs most frequently to small, non-verbal children that many go unreported (Dodge et al. 2004).

There are countless causes or factors involved in child maltreatment, including the mental illness of the parent or caretaker. Since the research is focusing on mental health disorders closely associated with child maltreatment, the focus of mental health will be limited to bipolar disorder, depression, schizophrenia, and Munchausen by Proxy, in that these are the most commonly found diagnoses within the child welfare system.

Depression is the most common of all psychiatric disorders, especially in the child protection field. Major depression is a mood disorder that affects the individual's emotional state and thinking. Symptoms of depression include prolonged feelings of sadness or hopelessness, difficulty concentrating, appetite changes, sleep disturbances, withdrawal or isolation, and suicidal ideations. Depression can begin at any age, and although it is highly treatable, some may battle with the disease their entire lifetime. Depression affects twice as many women as men, and one of seven women will suffer from depression at some time in their life (Risley-Curtis, Stromwell, Hunt, & Teska, 2004). Women of childbearing ages, between 18 and 45 years, represent the largest group of individuals with major depression and two-thirds of all diagnosed with depression are parents (Nicholson, Clayfield, 2004, p. 3). This explains why it is so prevalent in the social service arena.

Maternal depression is related to an increased likelihood of problems in behavior, emotion, and development in their children across the developmental age span. Evidence of major depression in a child welfare parent may include, not keeping up one's home, failing to provide meals for children or oneself, poor memory resulting in missed meetings or failing to keep previously agreed-upon obligations, beliefs that one's children are better off without her, resulting in missed visitation or abandonment; and suicidal thoughts and attempts (Casey, Goolsby, Berkowitz, Frank, et al. 2004).

Bipolar Disorder, a variation of depression that was actually once termed manic depression, is another popular diagnosis within the child welfare system. Bipolar Disorder has also been labeled as a mood disorder; however the diagnosis requires at least one occurrence of depression and one occurrence of mania. Bipolar disorder is inclusive of depressive characteristics as well as manic characteristics. Mania is portrayed as impulsive behavior, rapid speech, hyperactive behavior, irritability, reckless behavior, and decreased need for sleep (Risley-Curtis, et al. 2004).

According to Risley-Curtis, et al. (2004) "one percent of the general population is affected by bipolar disorder." Contrary to depression, bipolar disorder, occurs equally in men and women and has a strong genetic component. Bipolar disorder is commonly treated with mood stabilizers. This mechanism is not a cure, but simply an attempt to prevent or help minimize the recurrences of the depressive and manic episodes. Substance abuse usually goes hand in hand with bi-polar disorder: "60 % will develop a substance abuse disorder within their lifetime" (Risley-Curtis, et al. 2004, p. 4). Hallucinations or delusions often occur within a manic state; therefore it is frequently misdiagnosed as schizophrenia (Mueser & McGurk, 2004).

Schizophrenia is one of the most disabling mental disorders due to the symptoms that accompany the disease. Some of these symptoms include: hallucinations, psychosis, delusions, flat or unexpressive emotions, bizarre behavior, and lack of motivation or energy. Hallucinations can be defined as hearing, seeing, and sometimes smelling something that is not really there, whereas delusions are thoughts or perceptions not related to reality. These symptoms of schizophrenia lead to problems in social and occupational functioning and results in impaired performance in school, parenting, work, and self-care (Mueser & McGurk, 2004).

According to Mueser and McGurk (2004) schizophrenia affects about 1% of the US population (2004). The disease usually develops during adolescence or young adulthood, which results in women already being parents at the onset of the disease. The disease can often go misdiagnosed, untreated, and misunderstood for long periods of time, before there is an intervention. Within the population of those with schizophrenia, approximately 60% improve with treatment, with about 25% returning to highly functioning tasks of daily living. Antipsychotic medications are the foundation for managing schizophrenia. Along with the medications, psychosocial treatments are also used; including family intervention, supported employment, therapy, social skills training, and substance abuse treatment (Mueser & McGurk, 2004).

Munchausen Syndrome was named after Baron von Munchausen, an 18th century German aristocrat who was notorious for telling exaggerated stories of his adventures. Munchausen Syndrome was coined in 1951 by Richard Asher, a British physician, to diagnose patients who fake their own illnesses. British physician, Roy Meadow, followed Asher's lead and termed the disease Munchausen by Proxy for those individuals

who induce illnesses or fakes illness in someone else. The condition is considered a psychiatric illness in the parent as well as a form of child abuse (Goldstein, 2002). It is believed that the parent uses their child's self-induced illness to get attention for themselves. Many mothers will intentionally cause or lie about illnesses or disabilities in their children to initiate discussions with those in authority. The mother is often times perceived as a competent and involved parent which frequently leads to professional's failure to recognize the disease. Wanting others to perceive them in this way, may be to fulfill some psychological need in the mother (Goldstein, 2002).

The majority of Munchausen by Proxy cases are seen in women, approximately 95% of all adults diagnosed with the syndrome are women. The children are often times subjected to unnecessary medical exams, needless medications, unwarranted hospitalizations, and often times unnecessary surgical procedures. Some victimized children of Munchausen by Proxy have been poisoned to induce illnesses such as nausea, vomiting, headaches, and fatigue. According to Lisa Goldstein (2002) "researchers say that on average 600 cases of suffocation and poisoning related to Munchausen by Proxy occur each year in the United States." There are incidents in which this disease can lead to fatal consequences. "It is said that one in three children in such cases dies" (Randerson, 2003, p. 2).

Although the majority of Munchausen by Proxy cases focus on the physical ailments of a child, there is new research on this disease becoming more prevalent in the school system. Researchers have recently documented cases in which mothers have fabricated or induced educational disabilities in their children out of a pathological need to get attention for themselves. It is unknown why some individuals act in such a way,

however, “most experts believe it is intentional, and the mother knows she is doing it at the time she is doing it” (Goldstein, 2002, p. 4).

It is common knowledge that in order for a child to be healthy and develop routinely the child must have substantial care, trust, nurturing, and bonding with his/her parents. When a child is living in a home with mental illness the child often lacks in some of his basic needs. Important concepts for research in mother-infant interactions include the development of bonding and attachment as well as trust. This is established daily as the child grows in ordinary interactions between the child and his/her caretaker. A baby learns to trust through the routine experiences of being fed when they are hungry or held when they are upset or frightened. Children who get no help monitoring or regulating their behavior during the early years have a greater risk of becoming developmentally delayed (Thomas & Looney, 2004). This risk is something the child protection field must be mindful of when assessing families dealing with mental illness, if the parent is not receiving proper treatment for their mental health disorder.

The health and well-being of parents and children are intimately intertwined. Research indicates that mental illness not only places children at risk for developing psychosocial problems, but children’s needs and responses for not having their needs met adds burden to the parents (Nicholson & Clayfield, 2004). According to Pearl Schmier (2004) the following consequences of children living with a parent with active mental health illnesses must be considered: “lack of appropriate supervision, questionable judgment regarding appropriate alternative caregivers and the risks of abuse inherent in that, parentification of children, a skewed world view passed on to the children, inconsistent parenting, inconsistency in the parent’s personality, the needs of the children

for family, safety, stability, and permanency.” Social service workers must be mindful of these possible consequences, think of the best interest of the child, and rapidly link the parent to service providers that could be most beneficial to their certain illness.

Learning Disabilities

Various pressures within the household affect the outcomes of child rearing practices and ultimately the stability of children in the home. In recent years, much study and efforts have been concentrated on issues that affect parenting practices, particularly involving incidents of domestic violence and mental health issues in the home (DiLauro, 2004). Research has demonstrated that when left untreated, these various psychosocial factors could lead to a greater risk of child maltreatment, a greater risk of mental health problems within children and adolescents, and a greater likelihood of child placement outside the family home (Thomlison, 2003). Research over the years has expounded greatly on the outcomes of these phenomena, however, little research has been conducted on the effect of learning disabilities within at risk households.

Recent statistics show that 2.6 million school-age children have some form of learning disability within the United States (Learning Disabilities Association of America, 2004). Children are not the only population severely affected by learning disabilities within this country. O’Callaghan (1998) found that within the adult criminal population, a significant number of sexual offenders have been diagnosed with a learning disability, which may help to explain the careless impulsivity associated with these actions. Within the state of Kansas, following the measures instituted by the Temporary Assistance to Needy Families (TANF) program, many of the “hard-core” unemployed who remained on TANF rolls represented an extremely large proportion of learning

disabled individuals and today, over 50% of the TANF caseload in Kansas can be assumed to have learning disabilities, mental retardation, psychiatric or addictive disorders, or a combination thereof (Taylor & Barusch, 2004, p. 176). The previous examples mentioned point to the significant impact learning disabilities has on at-risk families throughout the United States.

Learning disabilities, unlike other disabilities such as paralysis or blindness, are a hidden affliction, making it much harder to understand. According to Elksnin and Elksnin (2004) learning disabilities are defined as follows:

Specific Learning Disabilities is a chronic condition of presumed neurological origin, which selectively interferes with the development, integration, and/or demonstration of verbal and/or nonverbal abilities. Specific learning disabilities exist as distinct handicapping conditions and vary in their manifestations and in degree of severity. Throughout life, the condition can affect self-esteem, education, vocation, socialization, and/or daily activities. (p. 4)

The American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders (2001) broadly defines the presence of learning disabilities into three broad categories: (1) developmental speech and language disorders (2) academic disorders and (3) other, a catch-all that includes certain disorders and learning handicaps, including motor skill disorders and social disorders, not covered by other terms. These definitions encompass much more than Intelligence Quotient (IQ) in children, which many in modern society falsely use to define learning disabilities (Siegel, 1989; Wong, 2003).

The increase in learning disabilities in parents is often attributed to numerous social occurrences over the past few decades. The actual prevalence of parents with learning disabilities is unknown; however, a large heterogeneous group of parents with learning disabilities are growing as a result of deinstitutionalization, decreased segregation, changing attitudes towards sexuality, and wider opportunities for independent living and participation in the community as a whole (Busch, 1996; Hatton, 2002). Accompanying these growing numbers of learning disabled parents are numerous myths that society holds true regarding the abilities and characteristics of learning disabled parents. According to Sheerin (1998) beliefs about learning disabled parents include (1) learning disabled parents will only produce learning disabled children, (2) learning disabled parents have more children than the average family, (3) learning disabled parents provide inadequate parenting to their children, and (4) learning disabled parents cannot learn adequate parenting skills.

Not only are learning disabled parents combating unfair stereotypes within the social landscape, significant changes in the national welfare system has drawn more attention to some at-risk families and created additional barriers to safety and well being in the home. According to Taylor and Barusch (2004), eight barriers have been identified that may affect a past TANF recipient's ability to transition from welfare to work, including physical disabilities, mental health problems, substance abuse, domestic violence, involvement with the child welfare system, and learning disabilities (p. 176). Contributing to TANF transition difficulties, many learning disabled adults cannot understand the specific policy requirements set forth by the legislation, or their personal rights as recipients of this program (McDonald, 2002). Due to these issues and changes

in the national welfare landscape, parents identified with intellectual disabilities are at a loss for assistance, and thus are targeted for child protective services more so than any other group (James, 2004; Llewellyn, Mayes, Russo, & Honey, 2003).

Research relating to child maltreatment has found that no single profile of perpetrator exists, but in most cases, different factors, including mental health issues, substance abuse, parent-child interactions, and poverty are at the core of these incidents (DiLauro, 2004). Research has linked mild learning disabilities with specific mental health diagnoses including, depression, anxiety disorders, psychosis, compulsions, eating disorders, and substance abuse (Hatton, 2002). Often, these lead diagnoses disguise the presence of learning disabilities and its correlation with acts of maltreatment in many homes (James, 2004). As a result of the combination of being raised in a home with at least one learning disabled parent, a child is 50% more likely to grow up with a learning disability him or herself (Learning Disabilities Association of America, 2004). Other risk factors for children in these homes include: poor school performance, a propensity for juvenile delinquent acts, depression, anxiety disorders, verbal development deficits, and a risk of physical and or sexual perpetration from outsiders to the family due to the vulnerability of parental judgments (James, 2004).

Numerous human service professionals encountering learning disabled parents have bantered about the concept of “good enough” parenting and what constitutes adequate childcare for decades (McGaw & Sturmey, 1993). When this applies to parents who are learning disabled the situations for determining appropriate skill level are exacerbated tremendously. Aside from meeting basic needs, parents are pushed to abide by educational and child labor laws, show love and affection for their children, and

provide an environment conducive to stability for a child (McGaw & Sturmey, 1994). Although many feel these factors to be of “second-nature” learning disabled parents struggle to follow these broad categories of acceptance due to personal and environmental issues. Within their developmental histories learning disabled parents are often second generation who lack adequate role models and receive almost no preparation for parenting (McGaha, 2002). Also of importance is that many intellectually impaired parents are socially isolated and often lack the skill and knowledge base to seek out disability assistance in times of crisis (Llewellyn & McConnell, 2002). One particularly strong factor that helps to determine the involvement of child protective services with a learning disabled parent is the presence of another adult who is able to give the extended daily support or possibly several other people able to help as required with matters beyond the parent’s own coping resources.

Providing adequate treatment planning to families affected by learning disabilities often hinges on building and maintaining social supports in the home. Often, due to the lack of natural supports for learning disabled affected families, formal outside services, including support groups and social service agencies are needed to maintain the stability of the home and safety of the children (Llewellyn & McConnell, 2002). The aspect of outside services intervention is of great importance when dealing with parents stricken with learning disabilities, however, human service workers providing services should take notice of important factors. Internal risk factors that make the individual with learning disabilities more vulnerable to negative outcomes include certain types of non-verbal learning disabilities, impulsivity, hyperactivity, and denial of one’s disability (Wong, 2003). Another problem associated with working with learning disabled parents

includes the lack of appropriately trained workers to deal with the breadth of competencies needed to teach parents about child development, health, safety, nutrition, and other basic skills taken for granted when working with other parents (Feldman, 2004). This is particularly problematic when talking about families with children in out of home care, as the Adoption and Safe Families Act of 1997 (ASFA) has mandated that children be moved to permanency within 12 months after removal, placing case workers and parents in a time-crunch situation to provide appropriate education, planning and support in the home of learning disabled parents (Dawson & Berry, 2002).

In efforts to combat issues associated with the ASFA time crunch and the intensity of services needed to deal with learning disabled parents, many states are implementing pilot programs targeted on these issues. Some agencies are training caseworkers to administer screening tools targeted at recognizing learning disabilities early on which to base referrals to specialists (Kramer, 1999). Also, intensive case management services targeted at teaching learning disabled clients self-directed childcare abilities with use of visual materials, audio materials, and appropriate prompting, are proving to be successful interventions for many learning disabled families (Feldman, 2004).

Domestic Violence

Research shows that domestic violence is present in anywhere from 10% to 50% of families living in the United States. Broken down annually, 116 out of 1000 women in the United States have been the victim of some form of domestic violence and 34 out of 1000 women in the United States have been the victim of severe acts of domestic violence (Dubowitz, Black, Kerr, Hussey, et al. 2001). Barry (2003) defines domestic

violence not as an isolated incident of violence between two people in an intimate relationship but as a cyclical pattern of violence in which the perpetrator will abuse the victim either physically, verbally or psychologically then seek forgiveness and the violence occurs again later. Barry (2003) goes on to define this cyclical pattern into three phases; “Tension-Building Phase, Acute Battering Phase, and Loving Contrition Phase” (60).

In the “Tension-Building Phase” the victim senses that the perpetrator is angry and does what is necessary to keep the peace. She may become reclusive in order to avoid the abuse and in some instances she feels as if she deserves what is about to happen to her. The perpetrator becomes angry at the victim for becoming reclusive and begins to fear that she will leave him. This leads to the “Acute Battering Phase” which is the actual abuse itself. The type of abuse may be “intimidation, physical assaults, sexual assaults, control, isolation or psychological attack.” Finally, the “Loving Contrition Phase” arrives and forgiveness is sought and granted. The couple enjoys this phase. The victim begins to hope that her relationship is returning to how it was in the beginning and the perpetrator begins to make promises that will never be kept (Barry, 2003). Barry goes on to say that as the relationship progresses the cycle of abuse becomes shorter and shorter with the most time being spent in the “Acute Battering Phase.” This cycle leads the victim to “hyper vigilance, anxiety, low self-esteem, and ‘learned helplessness’ (Barry, 2003, p.60).”

It is a well known fact that domestic violence is an enormous problem in our society today but only recently have researchers begin to focus on children who witness or are physically involved in domestic violence. Domestic violence is not only a danger

to the victim but to the children who witness and experience this abuse as well (Fantuzzo & Mohr, 1999). Carter, Weithorn, & Behrman (1999) and Saathoff and Stoffel (1999) reported that approximately 3.3 to 10 million children witness domestic violence each year. Additionally, Felson, Ackerman, and Seong-Jin (2003) reported that in 73% of families where domestic violence was present, child abuse was also occurring. Peled (2000) concluded that in 30% to 60% of families where there is either child abuse or domestic violence the other form of violence is also present. According to Dubowitz, Black, Kerr, & Hussey, et al. (2001) children witnessing domestic violence are at a greater risk to be abused by both their fathers and their mothers.

Jones, Gross, and Becker (2002) stated that there are many reasons that domestic violence and child abuse often coincide. The aggression in relationships in which domestic violence is present may “spill over” into the relationship between the parent and the child. Victims possibly learn from their own experience that violence is an effective means of control. Children may be hurt when intervening to protect a victimized parent. Jones, Gross, and Becker (2002) stated that a batterer may hit the child while the child is in the process of trying to protect their mother or the batterer may hit the child in an attempt to terrorize his partner.

As reported by Dubowitz, Black, Kerr, and Hussey, et al. (2001) and Jones, Gross, and Becker (2002) victims of domestic violence live a stressful life and are more likely to use parenting techniques that could be defined as abusive. Stressed victims were more likely to hurt a child when battered than when they are safe. The more violent the abuse, the more violent the victim is to the children. Victims of domestic violence have the highest rates of child abuse. Victims who were subjected to minor violence had more

than double the rates of physical assaults on children than did women not experiencing that kind of abuse. The victim may be attempting to make the children behave in an attempt to avoid getting abused herself. The perpetrator might also force the victim to discipline the child in an abusive manner (Jones, Gross and Becker, 2002).

Peled (2000) found that in 50% of families where both child abuse and domestic violence were present it was the same perpetrator in both the child abuse and the domestic violence, which in most cases was the adult male in the home. Peled (2000) stated that the child abuse occurred approximately twice a year which is seven times more than families where domestic violence was not present. Studies also showed that the abusive men were stricter with discipline than the abused women (Peled, 2000). Peled (2000) went on to say that once the abused woman leaves the abusive environment with her children it only increases the risk of the children to be exposed to some form of violence because it is at the time of separation that is the most dangerous to the abused women. This is the point when most abusers critically injure or even kill their partners. Research shows that women are 14 times more likely to be abused after they have left the abuser than women who are still living in the abusive household (Peled, 2000). Peled (2000) stated that the children are more likely to witness this abuse because it usually occurs when the parents are exchanging the children for visitation. Peled (2000) also reported that the abusive father uses the visitation with their children as a way of maintaining contact and control with both the mother and the children. Abusive fathers are also far more likely to try to obtain custody of their children and not pay any child support. They also use the children as a way to try to reunite with the children's mother (Peled, 2000).

Walton (2003) quotes Professor Jeffrey Edleson (Director of the Minnesota Center Against Violence and Abuse at the University of Minnesota School of Social Work) as stating “there are at least 100 studies documenting the negative effects for children exposed to domestic violence (33).” Some of these negative effects include attention problems, sleep difficulties, chronic headaches, stomachaches, phobias, low self-esteem, depression, poor academic and problem solving skills, low levels of empathy, behavioral problems, emotional problems, adjustment problems, anxiety disorders, truancy, aggression, Post Traumatic Stress Syndrome and are at a greater risk of becoming abusers, themselves, in adulthood (Carter, Weithorn & Behrman, 1999; Haaf, 2003; Rosenbaum & Leisring, 2003; Saathoff & Stoffel, 1999).

Heyman and Smith (2002), Mohr and Tulman (2000), and Rosenbaum and Leisring (2003) reported that children who witness domestic violence or are victims of child abuse are at risk for becoming violent adults. Rosenbaum and Leisring (2003) added that this is especially the case in male children. Research shows that 45% of male batterers witnessed domestic violence as a child (Rosenbaum & Leisring, 2003). Heyman and Smith (2002) completed a study on this subject and found that women who witnessed domestic violence and were the victims of child abuse had a significantly increased risk of abusing children and being both the abuser and victim of domestic violence. For men there was an increased risk of abusing children and being the abuser in a domestic violence relationship. Heyman and Smith (2002) stated that for every act of violence the man witnessed or was a part of increased his risk for abusing children by 13% and abusing a partner by 8%.

Chalk and King (1998/1999) stated that child maltreatment materialized as a real problem in the 1960s. They reported that this came about when doctors and medical professionals began to detect signs of severe maltreatment from children with injuries in all different stages of healing. With this knowledge advocates for children began to fight for mandatory reporting of child abuse. The reporting of child abuse became the first factor in child protection policy (Chalk & King, 1998/1999). Advocates for victims of domestic violence have been fighting for over thirty years to have the rights of these victims recognized and acts of domestic violence considered criminal. After years of fighting, lawyers, judges, and police began to enforce acts of domestic violence with harsher punishments. Chalk and King (1998/1999) revealed that these first steps in protecting children and victims of domestic violence, though small, were very important because for the first time these two forms of abuse have been recognized and “long-term efforts” have been put in place to remedy these problems (Chalk & King, 1998/1999). According to Walton (2003) lawmakers are now struggling to find an effective way to protect children who witness domestic violence. Zink, Kamine, Musk, Sill, et al.(2004) reported that Kentucky is one of only three states that require mandatory reporting of all incidents of domestic violence but only Alaska “defines domestic violence in the presence of a child as child abuse within its juvenile code (49).”

Findlater and Kelly (1999) stated that domestic violence is present within approximately one third of all child protection cases. Dubowitz, Black, Kerr, and Hulsey, et al. (2001) go on to say that 40% - 60% of all child protection cases have a family history of domestic violence. Historically, child protection has not focused its attention on domestic violence issues as social workers working with victims of domestic violence

have not been concerned with the needs of the children (Findlater & Kelly, 1999). In the past, community based domestic violence services saw the children who witnessed this abuse as “secondary” victims and paid them little attention because they were already overwhelmed with trying to meet the needs of their mothers (Saathoff & Stoffel, 1999). Saathoff and Stoffel (1999) went on to say that the philosophy back then was such, that as long as the mother’s needs were being met then she could ensure that her children were getting the help they needed. Unfortunately, Pennell and Burford (2000) reported that family violence has often been separated into child abuse and domestic violence. This separation does not cover the full magnitude of the abuse. Furthermore this separation has increased the distance between child protection and domestic violence services, which may prevent the family from receiving the safety they deserve. It is easy to understand why child protection and domestic violence do not typically work together (Pennell & Burford, 2000). “They originated from different social movements that generated their own programming and funding streams and maintained their distinctive functions, one of protecting children and the other of protecting adults within the family” (Pennell & Burford, 2000, p.132).

The primary goal in child protection is “family preservation”. This may imply to someone working in domestic violence that the emphasis is on keeping the family together no matter the dangers (Pennell & Burford, 2000). However, this is not an accurate assumption about child protection (Pennell & Burford, 2000). If there are risks and dangers present in the home they would not leave a child in that situation (Pennell & Burford, 2000). This is the same for domestic violence services. If there are risks and dangers to the victim, the domestic violence worker will do what they can to keep the

victim safe. It would be safe to say that child protection and domestic violence services share the common goal of “family unity” (Pennell & Burford, 2000). The family does not necessarily mean mother, father, and children. If the father is the abuser then family would be redefined as mother and children. Or if both the mother and the father are abusive to the children and the children are placed with grandparents then family would be defined as grandfather, grandmother, and children (Pennell & Burford, 2000).

According to Findlater and Kelly (1999) the systems are beginning to change and the two different service fields are starting to work together. The Massachusetts Department of Social Services was one of the first child protection agencies to address the issue of children living in homes where domestic violence is present and also work to protect their mothers as well. Massachusetts Social Services also assess the family on an ongoing basis to evaluate the risks to children witnessing domestic violence and furthermore create a safety plan with the mother on ways to protect herself and the children (Findlater & Kelly, 1999).

New information about the likely harms to children who are exposed to domestic violence has resulted in much distress for children in families in which domestic violence is present. The new policies that child protection workers must comply with in regards to domestic violence are focused around two main points: “(1) whether child witnessing of domestic violence constitutes child abuse or neglect; and (2) whether and when it is appropriate to remove a child from the custody of a battered mother because she has failed to protect her child” (Findlater & Kelly, 1999, p.88).

In an attempt to protect children, child protection workers and the court system may remove children from their homes if domestic violence is present, which in turn

penalizes the victimized mother (Baradaran-Robinson, 2003). All states have laws which describe child abuse or neglect in a phrase similar to “failure to protect a child from harm” (Findlater & Kelly, 1999). According to Baradaran-Robinson (2003) state government officials will often times remove children from their homes simply because the mother was unable to keep their children from witnessing the abuse she endures. It is mandatory that child protection workers and the court system work to keep the children safe at all costs and sometimes there are no other options than to remove the children from the home in which the abuse is occurring (Baradaran-Robinson, 2003). Findlater and Kelley (1999) stated, “CPS has begun to examine the circumstances under which the harm to the child is occurring, to better understand whether it is truly in the best interest of the child to be removed from the mother’s custody. There is growing understanding that a battered woman does not have control over the batterer’s use of violence, and that she may be choosing to stay with a batterer because she believes it is safer for herself and her child if they stay. There is also concern that, if a battered woman believes her child will be taken from her, she is less likely to acknowledge the violence and get help” (p.88).

Targeted Assessment Program

In April of 1999, the Kentucky Cabinet for Health and Family Services (CHFS) entered into a contract with the University of Kentucky Institute on Women and Substance Abuse to begin development of the Targeted Assessment Program (TAP) (Targeted, n.d.). The program’s goals were to identify and address barriers to family self-sufficiency among clients receiving services through CHFS. Clients specifically targeted were those involved with Family Support and Protection and Permanency to address the

often hidden barriers of substance abuse, domestic violence, mental health and learning problems. The first project site was located in Daviess County on January 24, 2000 with seven additional counties added by June 30, 2000 (Targeted, n.d.).

The Targeted Assessment Program has been described by American Public Human Services Association as a “powerful example of high performance collaboration” between a state and a university which has resulted in progressively innovative solutions to the challenges of serving the “hard-to-serve” clients of Kentucky’s public assistance and child welfare systems (J. Hayes, personal communications, July 9, 2004).

Since inception the program has evolved into 20 Kentucky counties. Assessment Specialists, who are employees of the University of Kentucky that work out of the county welfare offices, provide assessment, referral, pre-treatment and follow-up services focused on identifying and addressing the barriers of mental health, substance abuse, intimate partner violence, and learning problems among families who are eligible for temporary aid to needy families (TANF) (Daviess County). Clients are provided with a non-threatening atmosphere which fosters the development of a trusting therapeutic relationship and increases the likelihood of client follow through on the recommended course of action. The Specialists seek to identify the client’s unique circumstances and barriers to employment and/or family safety, and then to devise a customized plan for overcoming those barriers. The Specialists work with client and caseworker to facilitate appropriate referrals for services and assist with client engagement and follow through (J. Hayes, personal communications, July 9, 2004).

Eligibility for TAP services consists of client involvement in the child welfare system, an open child protective services case, eligibility for TANF, an income no greater

than 200% of the poverty level, and child in custody or with “return to parent” as a goal, established by the Cabinet (J. Hayes, personal communications, July 9, 2004). Clients may be referred to the Program at initial intake by an investigative worker to assist in determining the needs of clients as they first enter the system or an ongoing worker, as a last resort, may refer them before the case goal is changed to adoption, or at any point in between (J. Hayes, personal communications, July 9, 2004).

The primary objective of TAP is to address the multiple barriers facing Kentucky families who are being transitioned from receiving support to self-sufficiency (McArthur, 2001). For many recipients of TANF, access to job training, education, child-care, health care, housing and other traditional services are enough to help them move toward self-sufficiency, for others, however, multiple barriers significantly impede their ability to meet TANF requirements (McArthur, 2001). The four barriers to self-sufficiency that TAP addresses are substance abuse, mental health, intimate partner violence and learning disabilities. TAP defines substance abuse as the use of drugs or alcohol that affects social, physical, cognitive, legal or occupational functioning (TAP, 2004). Domestic violence is defined as currently experiencing domestic violence from a current or past intimate partner or still dealing with the effects of a past abusive relationship with an intimate partner (TAP, 2004). Poor mental health is defined as having an acute episode of a mental illness in the past year, having a chronic mental illness, or having a severe and persistent mental illness (TAP, 2004). Learning problems are defined as a suspected learning disability or a suspected learning deficiency. A learning deficiency is a lack of education due to poor educational opportunities or family issues such as dropping out of school because of an early pregnancy (TAP, 2004).

TAP data highlights reported for the fiscal year ending June 2004 indicated that of the 607 referrals made statewide, that 391 assessments were completed (TAP, 2004). Of the clients assessed, 50% revealed symptoms indicating substance abuse, 61% described current or past domestic violence experiences, 63% revealed mental health problems, 40% revealed learning problems, 75% of the clients were identified to have two or more barriers and 13% were identified as having intimate partner violence and mental health as the most commonly occurring combination of barriers (TAP, 2004). Highlights also reported the referrals TAP specialists made, if the referrals were accepted and first appointments kept and if clients were cooperative with services (TAP, 2004). Other highlights reported were client basic needs: housing; transportation; employment or job search; medical care; legal services; child care; cash; and other basic needs. Of the 391 client's assessed, 358 reported at least one basic need. The total number of basic needs reported was 710, which indicates possible multiple needs in some client families (TAP, 2004). Mental health problems continue to be the most prevalent barrier for TAP clients, either alone or in combination with other problems (Targeted Assessment, n.d.).

Future Research

The Targeted Assessment Program appears unique in that assessors are co-housed in local child welfare agencies and pre-treatment, referral and after care services are provided in one setting by one assessor. Hard to serve populations who experience transportation difficulties can access those services necessary to address their needs at one site. TAP has been instrumental in targeting clients transitioning from welfare to self-sufficiency, who were not prepared to enter the workforce as result of a mental illness, substance abuse, domestic violence or learning disability. Through TAP referral

services clients are linked with resources that will better prepare them for successful transition to independence.

Welfare reform has been instrumental in transitioning able bodied clients to self-sufficiency but has only begun to address the numerous barriers that prevent many from successful transition. Research into the specific barriers, duration, frequency and cause would enable the worker to connect with the client's needs earlier, possibly decreasing the amount of time a client's case remains open with the CHFS. Reunification efforts and time frames need to parallel that of parental rehabilitation time, in order to ensure long term success. Research should focus on hard to reach clients, apprehensive in seeking help, out of fear of child removal.

Approaches to working with clients, defined as hard to serve, are as diverse as the needs and wants they struggle with daily to survive and the Social Workers they turn to for assistance. Literature reviewed for this research indicated four primary barriers that often negate the possibility of successful transition from welfare to self-sufficiency. Implementation of appropriate screening tools utilized by the worker can provide early client intervention to address those barriers of mental illness, substance abuse, domestic violence and learning disabilities to adequately measure the extent and degree of the problem to tailor services appropriately.

Literature reviewed revealed a theme that the health and well being of the parent and child are intimately intertwined. Children become at risk of maltreatment and developing psychosocial problems when barriers are not addressed that would promote parental transition from welfare to self-sufficiency. Barriers often hinder the parent from fully understanding specific policy requirements regarding time frames for child

reunification. Parents involved in substance rehabilitation find that their recovery time often exceeds the amount of time reunification stipulates to have their child(ren) returned to the home. This could potentially lead to permanent loss of the child. Workers were found to not be appropriately trained to deal with the breadth of client needs as a result of any of the four barriers.

As the research has indicated, child maltreatment and open cases with the CHFS are synonymous with parents who are faced with any of the four barriers. Through research, strengths and weaknesses of TAP will be identified to assist in further program development to improve upon addressing the many barriers that clients present.

This research will attempt to substantiate the hypothesis that CHFS clients involved in TAP will have fewer instances of repeat referral for child maltreatment and cases closed sooner than those clients who are not involved in TAP. Qualitative analysis of chart data and CHFS worker interview will attempt to determine factors of involvement in TAP that has resulted in decreased referrals due to child maltreatment and decreased amount of time of open CHFS case. Quantitative analysis of chart data and worker interview will be gathered to determine if TAP keeps repeat referrals of maltreatment down and decrease the amount of time a case is open.

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Method

Study 1: Quantitative Approach

Research Question

What is the relationship between the Targeted Assessment Program and child protective services cases?

Sample

The sample will be taken from families with closed child protective services in Daviess and Henderson Counties in Kentucky between September 1, 2001 and September 1, 2004. Closed is defined as a case that was no longer receiving services from the Cabinet for Health and Family Services, Division of Protection and Permanency, as of September 1, 2004. The table of random numbers will guide the selection of 50 cases from each respective county. Twenty-five cases will be randomly selected in Daviess and Henderson Counties, respectively, based on participation with the Targeted Assessment Program. Twenty-five cases will be randomly selected in Daviess and Henderson Counties, respectively, based on non-participation with the Targeted Assessment Program. Henderson and Daviess Counties were chosen for comparison due to similarities in size, availability of services, and participation in the Targeted Assessment Program.

Research Design

A pre-experimental, static group comparison design will be employed in this study.

Description of Key Variables

Key variables for the research will include demographic information such as: age of parent, ethnicity, age of child(ren), number of children in home, type of household, income, source of income, employment, and education level of parent. Other key variables will include: type of maltreatment, number of previous referrals, number of previous removals, number of months case opened, referral to Targeted Assessment Program, and reason for Targeted Assessment Program referral (see Appendix A).

Data Collection Procedures

Data will be collected through assessing information obtained through a chart file review. Appendix A lists the information to be obtained during the review (see Appendix A).

Consent Procedures

Existing data will be reviewed for this study. Confidential information obtained through the chart review will be available only to the researchers and will be accessed at the Cabinet for Health and Family Services offices where they are kept as part of regular business. No identifying data will be collected from the chart review.

Method

Study 2: Qualitative Approach

Research Question

What characteristics of TAP lead to successful outcomes in Child Protective Services?

Respondent Pool

Personal interviews will be completed with four CHFS Social Workers and two TAP Specialists in their respective offices.

Research Design

The research design for this study will be based on the grounded theory methodology. The interviewing technique will utilize minimal structure interviews. A constant comparison analysis will be conducted, and themes will be identified as suggested by coding.

Description of Key Variables

The key variable of the qualitative research is to discover if workers find that TAP is beneficial to their clients in areas of safety and well-being for their families. Another variable would to determine if workers have noticed differences in the outcomes achieved by families that receive TAP services and families that do not receive TAP services.

Data Collection Procedures

Data was collected by interviewing four social workers and two TAP Specialists using the Narrative Analysis approach. Interviews were transcribed by the researchers. Line by line coding will be utilized to identify dominant themes. A constant comparison analysis was utilized (see Appendix B and Appendix C).

Consent Procedures

Informed consent was obtained from all participants. All participants were informed that they could terminate the study at any time. All written materials will be securely stored (see Appendix D).

Appendix A

Study 1

Quantitative Approach

Chart Review

Appendix A-Quantitative Approach-Chart Review

1. Type of household (single parent family, blended family, two parent household)
2. Number of children living in the home
3. Henderson or Daviess County
4. Does family live in rural or urban setting
5. Age of TAP recipient
6. Age of second parent in the home (if applicable)
7. Gender of TAP recipient
8. Gender of second parent in the home (if applicable)
9. Age of oldest child in the family
10. Age of youngest child in the family
11. Ethnicity of TAP client
12. Education level of TAP client
13. Paid employment income
14. Disability income
15. K-TAP income
16. Social Security income
17. Other income
18. Date case was opened
19. Type of maltreatment
20. TAP referral date
21. Which phase of case was family referred to TAP (Investigative or Ongoing)
22. Primary reason referred to TAP
23. Secondary reason referred to TAP
24. Date DCBS case closed
25. Number of CPS referrals prior to TAP intervention
26. Number of CPS referrals after TAP intervention
27. Has there been a case open prior to this current case
28. Were the children ever removed
29. How many times were the children removed
30. Number of months children were placed out of home

31. Have rights been terminated for any other children in the family?

32. Number of days case opened?

33. TAP involvement?

Appendix B

Study 2

Qualitative Approach

DCBS Worker Interview Questions

Appendix B-Qualitative Approach-Questions

DCBS Workers

1. How long have you been employed with the Cabinet?
2. What is your educational background?
3. Tell me about your experiences with TAP.
4. Do you feel that TAP benefits your families, how or how not?
5. How many of your cases have TAP involvement?
6. What are the major issues impacting your families involved with TAP?
7. Do you notice any differences between your cases that are involved with TAP and those who are not?
8. Have you noticed if there is a decrease in maltreatment with families receiving TAP?
9. How is TAP most effective with your families?
10. Have you noticed if your cases are getting closed quicker if they are provided TAP services?
11. Are there any negative experiences you have had with TAP?
12. Why do you refer families to TAP?
13. Do you support the TAP program? Why or why not?
14. Are there some families that benefit more from TAP than others (such as; do those with substance abuse issues respond more than those with mental health issues)?
15. What do your families that have TAP gain that clients without TAP miss out on?

Appendix C

Study 2

Qualitative Approach

TAP Specialist Questions

Appendix C- Qualitative Approach-Questions

TAP Specialist

1. How long have you been employed with TAP?
2. What is your educational background?
3. Tell me about some of your experiences with DCBS staff and families.
4. Why are most families referred to TAP?
5. In what stage of the case are they referred?
6. Does this make a difference?
7. What is the most beneficial thing about TAP?
8. What are some negative experiences if any that you have encountered?
9. On average how long do you typically work with a family?
10. What are some obstacles that you may encounter?
11. Are you aware if there are any instances of repeat maltreatment after TAP?
12. Is your caseload workable?
13. How many families do you have at this time?
14. What is the largest number of cases that you can work with?
15. How much contact do you have with your families?
16. Which groups benefit more from TAP (substance abuse, mental health, learning disabilities, or domestic violence)?

Appendix D

Study 2

Qualitative Approach

Consent Form for Interviews

The Relationship Between the Targeted Assessment Program and Child Protection Services

Subject Informed Consent

Introduction and Background Information

You are invited to participate in a research study. The study is being conducted by Dr. Nancy Keeton and Michelle Baize, Tonya Blandford, Lisa Bosley, Brandon Harley, Kim Osborne, and Helen Young. The study is sponsored by the University of Louisville, Department of Social Work. The study will take place at Department of Community Based Services in Henderson County and Daviess County. Approximately 12 subjects will be invited to participate. Your participation in this study will last for approximately 1 hour.

Purpose

The purpose of this research study is to compare families that have been involved and utilized services offered through the Targeted Assessment Program, TAP, and families that have not.

Procedures

In this study, you will be asked to participate in an informal interview conducted by one member of the team listed above. A total of ten participants will be chosen from Henderson and Daviess Counties. The participants will be chosen from a random sample of DCBS Social Workers. A TAP Specialist from both Henderson and Daviess Counties will also be interviewed. Interviews will be conducted in the DCBS offices of Henderson

and Daviess Counties and will last approximately one hour. The participant will not be forced to answer a question, if the question makes the participant uncomfortable.

Potential Risks

There are no identifiable risks.

Benefits

The possible benefits of this study include identifying the advantages to families who are provided services by the Targeted Assessment Program as compared to those who are not. The information collected may benefit the families receiving services through the Department for Community Based Services to see if there is less repeat maltreatment and less time the case may be open.

Confidentiality

Although absolute confidentiality cannot be guaranteed, confidentiality will be protected to the extent permitted by law. The study sponsor, the Institutional Review Board (IRB), the Human Subjects Protection Program Office (HSPPPO), or other appropriate agencies may inspect your research records. Should the data collected in this research study be published, your identity will not be revealed.

Voluntary Participation

Your participation in this research study is voluntary. You are free to withdraw your consent at any time without penalty or losing benefit to which you are otherwise entitled.

Research Subject's Rights and Contact Persons

You acknowledge that all your present questions have been answered in language you can understand and all future questions will be treated in the same manner. If you have any questions about the study, please contact Michelle Baize, Brandon Harley, Kim Osborne, or Helen Young at (270) 687-7491, or Tonya Blandford at (270) 826-6203, or Lisa Bosley at (270) 688-9000, or Nancy Keeton at (270) 686-4220.

If you have any questions about your rights as a research subject, concerns or complaints about the research or research staff, you may call the HSPPO (502) 852-5188. You will be given the opportunity to discuss any questions about your rights as a research subject, in confidence, with a member of IRB. The IRB is an independent committee composed of members of the University community, staff of the institutions, as well as lay members of the community not connected with these institutions. The IRB has reviewed this study.

Consent

You have discussed the above information and hereby consent to voluntarily participate in this study. You have been given a copy of the consent.

Signature of Subject

Date Signed

Signature of Investigator

Date Signed

Appendix E

Study 1

Quantitative Data Analysis

Quantitative Data Analysis

DCBS/TAP Clients

Appendix F

Study 2

Qualitative Data Analysis

Qualitative Analysis

Social Service Worker Interviews

Interviews were conducted with four Department for Community Based Services (DCBS) Social Service Workers (SSW) who utilize the Targeted Assessment Program (TAP) on a regular basis. Among the four interviews conducted, several common traits were identified between the workers. For instance, the four SSW's interviewed all had a minimum of two years of experience with DCBS with their average length of employment being six years. Three of the four workers hold a Master's degree in Social Work and the remaining worker has a degree in Criminal Justice. All of the workers interviewed were female.

A common thread that emerged during the interviews was the SSW's belief that TAP is a valuable service to DCBS clients. The workers identified at least six areas in which they believe TAP benefits their clients. The six areas include: the client/TAP specialist relationship, the SSW/TAP specialists relationship, the prompt delivery of services to clients, the convenience of co-housing TAP in DCBS offices, the TAP specialists ability to link clients to appropriate community resources, and the fact that TAP serves a population that might otherwise fall through the cracks due to inability to pay.

The relationship between the client and TAP specialist was viewed as a significant benefit because of the rapport that often develops between the specialist and the TAP recipient. According to the workers, the TAP specialist is often regarded as an advocate by the client. The workers believed that DCBS workers are often perceived in an adversarial role based upon the involuntary nature of CPS work.

The workers shared the opinion that feed back from the TAP specialist was instrumental in the casework planning process. The workers believed that through collaboration with the TAP specialist an atmosphere of teamwork is fostered in which the TAP specialist and SSWs work collectively to address the needs of the clients.

All workers viewed the expediency of the program as a substantial benefit to their clients, referring specifically to the speed in which clients are seen for assessment and the promptness in which TAP assessment results are received. The workers indicated that timely assessments assist them and their clients in identifying the goals and objectives that must be achieved in order to reduce the risk of repeat maltreatment.

Another aspect of TAP, which the workers viewed as advantageous for clients was the convenience and location of the program. Several of the workers referred to a “one stop shop approach” for services. The workers indicated that because TAP and DCBS are co-housed clients are often able to coordinate appointments; therefore, reducing demands on the client’s time and resources. Transportation was identified by workers as a frequent obstacle for DCBS clients as well scheduling difficulties. The SSW’s viewed the TAP specialist’s ability to make home visits if necessary and the TAP specialist’s ability to work with the client’s schedule as an added bonus.

Another significant benefit identified was TAP’s ability to link the client with appropriate community resources. Workers indicated that TAP specialists not only link families to services, but provide follow up services to ensure that a family’s needs are being met. If there is a breakdown in service delivery, the TAP specialist will attempt to identify the problem area and offer solutions in an effort to get the client back on track.

Finally, the most prevalent theme identified as a benefit of TAP is the fact that it is free. The workers indicated that the majority of their families already face significant stress and financial concerns. As one worker stated, “requiring a client to complete an assessment with an outside agency just places an additional financial burden the client and possibly contributes to an increased risk of repeat maltreatment”.

All workers interviewed stated that the majority of the cases they refer to TAP involve substance abuse and mental health issues. Some of the social workers reported that they refer all of their high-risk cases to TAP for assessments. The workers agreed that clients with learning disabilities were referred less often than clients who have substance abuse, mental health, or domestic violence issues. Some of the workers reported that they try to reserve TAP services for their high-risk cases and parents with learning disabilities typically do not present a high risk to their children.

In considering the length of time that CPS cases remain open for services, three of the workers believed that TAP involvement had a positive influence on cases being closed more quickly. The remaining three workers did not believe that there was a significant correlation between TAP involvement and case closure. Those SSW's who believed that TAP had a positive impact on case closure, shared that it was their experience that clients are assessed more quickly by TAP than when clients are referred for assessment to an outside agency. The workers reported that once the TAP assessment is completed and the client has followed all of the recommendations of the TAP specialist, the case can then be assessed for closure. The three workers did not believe that TAP had a significant impact on case closure, based their opinion on the type of cases referred to TAP. These workers related that typically the cases referred for TAP

services are cases, which have been classified as high risk. The workers stated that high-risk cases generally require monitoring for longer periods of time than cases, which have been identified as moderate or low risk.

All of the social workers agreed that they do see a decrease in repeat maltreatment with cases that are involved in TAP. The reason for this is that the cases are being monitored not only by the social worker but also by the TAP worker. The social worker and TAP worker usually work together and are able to address issues in the client's life before it results in maltreatment. Again the social workers referred to this as the team approach surrounding the family.

TAP Specialist Interviews

There were two Targeted Assessment Program (TAP) specialists interviewed for the purposes of the qualitative section of the research. After analyzing the data obtained in the interviews of the TAP specialists, there were some common characteristics found throughout. Although many of the themes were positive traits of TAP the specialists also shared some negative experiences and obstacles that they have encountered.

Both interviews revealed that the specialists feel that they are beneficial to DCBS and clients, for numerous reasons. The analysis revealed common repetitive statements such as: TAP fills gaps in services, provide middle man negotiation, help clients contact and obtain resources in the community, and provide close consistent contact with their clients.

Another commonality recognized is that the referrals are usually received during the investigation phase of the DCBS case. The specialists felt that this was a positive thing for them. The two therapists stated that clients are more motivated and cooperative in the beginning. They stated that they have noticed when they receive referrals after a case has been open for a while; families are more hesitant to work with them.

Although the two specialists had numerous positive themes about TAP, there were also negative themes that spread throughout the interview. Both of them stated that the most difficult part of their job are the lack of services available and waiting lists that accompany the services, which hinders treatment of clients. Both counties have limited resources and feel that there is a real need for substance abuse resources, especially inpatient, and mental health providers.

Some negative experiences they have encountered stem from the heavy and oversized caseloads of the DCBS workers. This can be problematic because DCBS workers and the clients do not have consistent contact with each other; therefore, they don't know each other well. A difference between the TAP workers opinions is that one worker felt that TAP can collaborate with the clients to identify and work on issues but it is sometimes is not enough to please the DCBS workers or the court system.

Another difference is that the Henderson specialist stated the majority of the referrals received consist of substance abuse and domestic violence, whereas the Daviess county office receives more referrals for mental health and domestic violence.

There was no definite reason found in the interviews of why these two areas were the most commonly referred.

Findings

This study has sought to determine the influence of the Targeted Assessment Program (TAP) on outcomes, widely considered positive, concerning the Child Welfare System. The sample of 100 families with closed child protective services from a split between Daviess and Henderson Counties in Kentucky revealed how TAP services have affected these families and the outcomes of their cases. In the sample, 47% were found to be single-parent families, 33% were two-parent families, 17% were blended families, the result of divorced or single parent families combining, and 3% were families considered to be headed, often times by grandparents or other significant family members. Within the sample, 32% of families had one child in the home, 43% had two children in the home, 20% for families had three children in the home and 5% had more than four children in the home. The family settings of the sample revealed that 75% of families lived within the city limits of either Henderson, KY or Owensboro, KY, while the other 25% lived within the county or rural settings. The mean age of the heads of households studied was 30.8 years. Eighty-five percent of the households studied were headed by a female, which included mothers, grandmothers, and aunts. Eighty-seven percent of the families studied were Caucasian, 11% were African American, 1% were considered bi-racial, while the remaining 1% was unable to be classified. Of the sample studied, 24% held high-school diplomas, 12% did not complete high-school, 6% held GEDs, 2% were college or technical school graduates. In 53% of cases, the education level of the head of household were unable to be determined. Regarding income levels, 54% of families had paid employment income, 12% received Social Security Insurance income, 20% received K-TAP financial assistance funding, 5% received Social Security

Disability income. In 27% of the families studied, income information was unable to be determined. The findings revealed that in cases receiving TAP services, 29 were opened due to neglect, 7 were opened due to physical abuse, while 14 were opened for other reasons, included court-mandate. In the non-TAP cases studied, 31 were opened due to neglect, 11 were opened due to physical abuse, while 8 were opened for other reasons. In TAP receiving cases, 25 had noted substance abuse issues as a contributing factor to child maltreatment, 11 had contributing mental health issues, 10 had contributing domestic violence issues and in 2 other contributing reasons were noted. In non-TAP receiving cases, substance abuse was a contributing factor in 13 cases, mental health issues were a contributing factor in 6 cases, domestic violence was a contributing factor in 9 cases and in 20 cases, other causes contributed to maltreatment issues.

The direct link between positive child welfare outcomes and involvement in Targeted Assessment Program services revealed confounding results. One aspect of consideration, the correlation between TAP involvement and the number of times a child was removed from the home revealed an insignificant finding. This may be attributed to the themes of both workers and TAP Specialists interviewed in this study, who both noted that TAP is often utilized in high-risk, tenuous case, where children may be removed from the home often because of ongoing and repetitive safety hazards. When discussing another positive outcome in child welfare, reduction of recidivism, statistical results again revealed insignificant statistical results regarding TAP involvement in cases. Although DCBS workers interviewed indicated the expediency of the TAP referral process, especially in the high-risk cases which are often referred, TAP Specialist often lack the community resources to quickly assist in discontinuing or treating the presenting

problem, which may subside future incidents of maltreatment. Also of note, one TAP Specialist noted, “having TAP services in the home allows an extra set of eyes to see what is going on, which may or may not lead to further reports of child maltreatment.” The final outcome studied, TAP’s effect on the timeframes a case is opened, revealed a significant, very low negative correlation. This infers that TAP’s involvement in ongoing casework in the child protective services cases in Henderson and Daviess Counties is weakly related to cases being closed slightly faster. As indicated in the qualitative section of this study, most TAP referrals are made during the investigative phase of involvement, thereby front-loading services to clients, and avoiding long referral waiting lists. This common area of concern noted in the qualitative discussion impedes progress during the crucial moment of motivation following initial contact with DCBS workers and TAP Specialists.

Overall, the hypothesis that TAP involved cases have lesser incidents of repeat maltreatment was not supported by the findings. As noted, child maltreatment cases present a array of problems with varying degrees of seriousness for consideration. In consideration for involvement with TAP services, often, workers reported that the most serious cases within the agency are often referred, thereby, possibly negating the possibility of quick closure. Often, TAP Specialist report that client problems are confounding and require numerous levels of community partner involvement belated by long waiting lists for a finite amount of services. However, TAP services, as reported by DCBS workers themselves pose a great amount of strengths, including in-house collaboration, quick response times and extra help in monitoring the safety and wellbeing of Daviess and Henderson Counties’ most susceptible populations.

Limitations

Limitations of this study included the lack of specific demographic information, most notably, education and income level, of DCBS clients as documented in The Worker Information System (TWIST). Although sections in TWIST are provided to enter such information, the practice is not unilaterally enforced, therefore the most accurate information regarding families could not always be obtained. Other limitations included the inability to access actual Targeted Assessment Program case records regarding clientele due to Federal Privacy Protection Laws concerning substance abuse and mental health issues. Also, there is little documentation in TWIST regarding the actual problem areas of TAP assesses of the major four areas: mental health, substance abuse, domestic violence and learning disabilities. Access to TAP records could aid future research in helping to determine what areas for which TAP is most effective of the four targeted barriers outlined. Another area of concern centered on the lapse of time this project group endured awaiting approval from various Institutional Review Boards, particularly the review board associated with the Cabinet for Health and Family Services. Finally, there were additional problems with documentation regarding the services rendered the client through the Targeted Assessment Program as well. As determined through the qualitative analysis, TAP Specialists work with family on varying levels, beginning with assessment, all the way through follow-up and termination. At times, services through TAP may be limited to only the initial assessment, while other DCBS clients may receive ongoing support from the TAP Specialist throughout and after termination of DCBS cases. With limited information regarding TAP services,

determining the most effective aspects of TAP for DCBS involve clientele is difficult to determine.

Future research should focus on which issue TAP services provide the most benefit to DCBS clients. As noted, child protective services clients often present an array of problems simultaneously. By determining which cases for which TAP is most effective, the program may either become more inclusive or streamlined to target specific families for services, therefore assisting DCBS workers in providing more efficient and faster services to repair family problems. The inception of the Targeted Assessment Program was never meant for use with child protective services, as its roots are centered in TANF and reform initiatives to assist financially dependent families. Future studies may consider comparison of outcomes associated between the child welfare system and those clients of Public Assistance Services as outlined in programs such as K-TAP and medical assistance housed in county Family Support Offices throughout Kentucky.

Appendix E
Quantitative Code Book

Quantitative Code Book

Variables

- | | |
|---|---|
| 1. household – Type of Household | 1-Single-Parent
2-Two-Parent
3-Blended Family
4-Other |
| 2. nbch – Number of Children in Home | |
| 3. county – County Family Lives In | 1-Daviess
2-Henderson |
| 4. famset – Setting Family Lives In | 1-Urban
2-Rural
3-Other |
| 5. aop – Age of Parent | |
| 6. aop2 – Age of Second Parent in Home(if applicable) | |
| 7. gender1 – Gender of Head of Household | |
| 8. gender2 – Gender of Second Parent in Home(if applicable) | |
| 9. aoc – Age of Oldest Child | |
| 10. ayc – Age of Youngest Child | |
| 11. race – Head of Household's Ethnicity | 1-African American/Black
2-Asian/Pacific Islander
3-Hispanic
4-Native American
5-Unable to Determine
6-White/Caucasian |
| 12. grade – Highest Grade Completed by
Head of Household | |
| 13. employ – Paid Employment Income | |
| 14. ssi – Disability/SSI Income | |
| 15. ktap – KTAP Income | |

- | | |
|---|--|
| 16. socsec – Social Security Income | |
| 17. other – Other Income | |
| 18. dco – Date Case Opened | |
| 19. maltx – Type of Maltreatment | 1-Neglect
2-Physical Abuse
3-Sexual Abuse
4-Other |
| 20. refdate – Date of TAP Referral | |
| 21. phase – Phase Case Referred to TAP | 1-Investigation
2-Ongoing |
| 22. reason – Reason Case Referred to TAP | 1-Domestic Violence
2-Learning Disability
3-Mental Health
4-Substance Abuse |
| 23. reason – Second Reason Referred to TAP | 1-Domestic Violence
2-Learning Disability
3-Mental Health
4-Substance Abuse
5-Does Not Apply |
| 24. closed – Date Case Closed | |
| 25. prior – Number of Referrals Prior to TAP | |
| 26. after – Number of Referrals After TAP | |
| 27. openprior – Case Open Prior to Current Case | 1-yes
2-no |
| 28. removed – Children Removed | 1-yes
2-no |
| 29. xremoved – Number of Times | |
| 30. xmonths – Number of Months Children Out of Home | |
| 31. terminat – Parental Rights Terminated | 1-yes
2-no |

32. nodays – Number of Days Case Opened

33. tapy – TAP Involvement

1-yes

2-no

34. tapn – No TAP Involvement

1-no

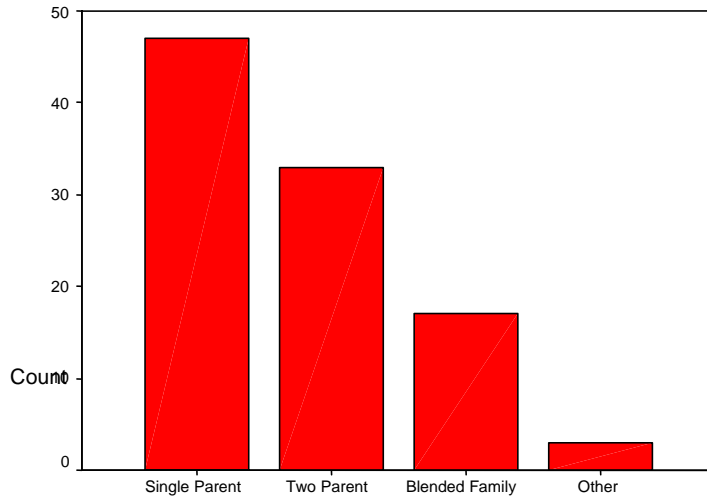
2-yes

Appendix F

Power Point Presentation

QUANTITATIVE ANALYSIS

Type of Household



47 single parent families (non-gender specified), 33 two-parent families defined as a father and mother, 17 blended families, and 3 other-type households were included in the study.

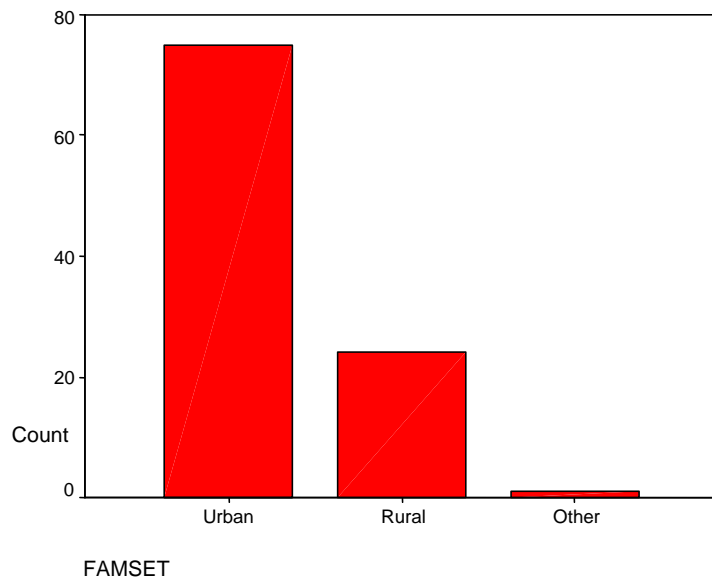
Number of Children in the Home

NBCH

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00	32	32.0	32.0	32.0
	2.00	43	43.0	43.0	75.0
	3.00	20	20.0	20.0	95.0
	4.00	3	3.0	3.0	98.0
	5.00	2	2.0	2.0	100.0
	Total	100	100.0	100.0	

32 families had 1 child in the home, 43 families had 2 children in the home, 20 families had 3 children in the home, 3 families had 4 children in the home and 2 families had 5 children in the home.

Family Setting



75 families live in an urban setting, defined as living within the city limits of Owensboro or Henderson Kentucky. 24 families live in a rural setting, defined as living outside of Owensboro or Henderson city limits. 1 family lived in a setting that was unable to be determined.

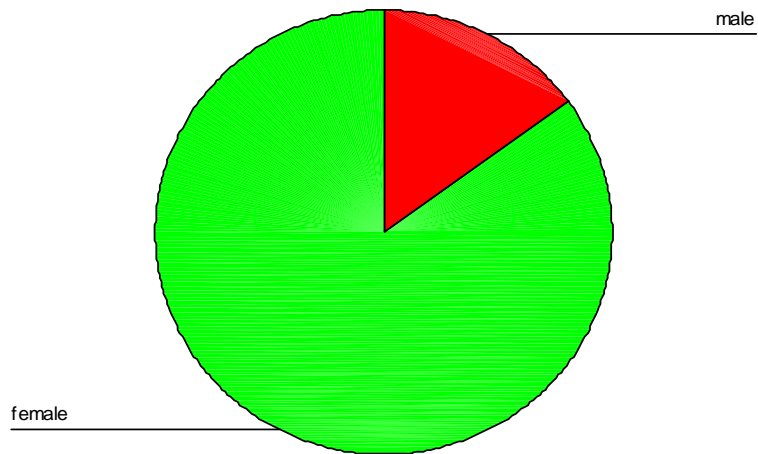
Age of Head of Household

AOP

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	17.00	1	1.0	1.0	1.0
	18.00	2	2.0	2.0	3.0
	19.00	1	1.0	1.0	4.0
	20.00	4	4.0	4.0	8.0
	21.00	3	3.0	3.0	11.0
	22.00	3	3.0	3.0	14.0
	23.00	6	6.0	6.0	20.0
	24.00	4	4.0	4.0	24.0
	25.00	3	3.0	3.0	27.0
	26.00	7	7.0	7.0	34.0
	27.00	8	8.0	8.0	42.0
	28.00	2	2.0	2.0	44.0
	29.00	3	3.0	3.0	47.0
	30.00	6	6.0	6.0	53.0
	31.00	6	6.0	6.0	59.0
	32.00	5	5.0	5.0	64.0
	33.00	6	6.0	6.0	70.0
	34.00	2	2.0	2.0	72.0
	35.00	4	4.0	4.0	76.0
	37.00	3	3.0	3.0	79.0
	38.00	7	7.0	7.0	86.0
	39.00	6	6.0	6.0	92.0
	40.00	2	2.0	2.0	94.0
	42.00	1	1.0	1.0	95.0
	43.00	1	1.0	1.0	96.0
	48.00	1	1.0	1.0	97.0
	54.00	1	1.0	1.0	98.0
	63.00	1	1.0	1.0	99.0
	76.00	1	1.0	1.0	100.0
	Total	100	100.0	100.0	

The minimum age of head of households studied was 17 years, the maximum age of head of household was 76, and the mean age of head of household is 30.8 years.

Gender of Head of Household



85 head of households were female. 15 head of households were male.

Ages of Children

AOC

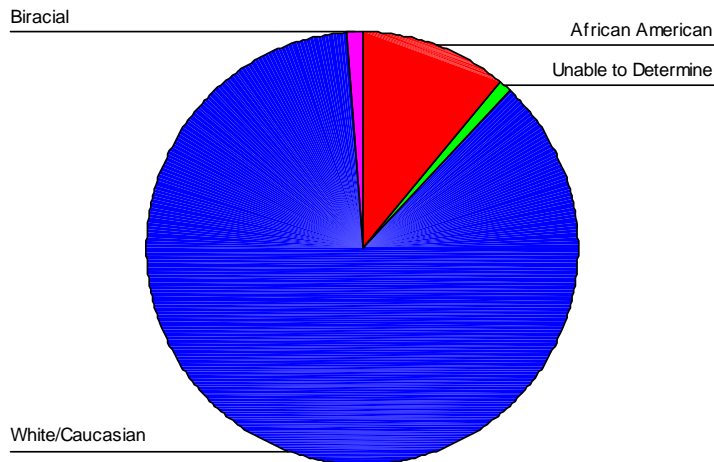
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not applicable	5	5.0	5.0	5.0
	1.00	3	3.0	3.0	8.0
	2.00	8	8.0	8.0	16.0
	3.00	5	5.0	5.0	21.0
	4.00	10	10.0	10.0	31.0
	5.00	4	4.0	4.0	35.0
	6.00	5	5.0	5.0	40.0
	7.00	6	6.0	6.0	46.0
	8.00	11	11.0	11.0	57.0
	9.00	2	2.0	2.0	59.0
	10.00	6	6.0	6.0	65.0
	11.00	4	4.0	4.0	69.0
	12.00	3	3.0	3.0	72.0
	13.00	7	7.0	7.0	79.0
	14.00	7	7.0	7.0	86.0
	15.00	4	4.0	4.0	90.0
	17.00	10	10.0	10.0	100.0
	Total	100	100.0	100.0	

AYC

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	not applicable	42	42.0	42.0	42.0
	1.00	9	9.0	9.0	51.0
	2.00	4	4.0	4.0	55.0
	3.00	3	3.0	3.0	58.0
	4.00	6	6.0	6.0	64.0
	5.00	7	7.0	7.0	71.0
	6.00	5	5.0	5.0	76.0
	7.00	2	2.0	2.0	78.0
	8.00	2	2.0	2.0	80.0
	9.00	6	6.0	6.0	86.0
	10.00	4	4.0	4.0	90.0
	11.00	4	4.0	4.0	94.0
	12.00	2	2.0	2.0	96.0
	13.00	2	2.0	2.0	98.0
	15.00	1	1.0	1.0	99.0
	16.00	1	1.0	1.0	100.0
	Total	100	100.0	100.0	

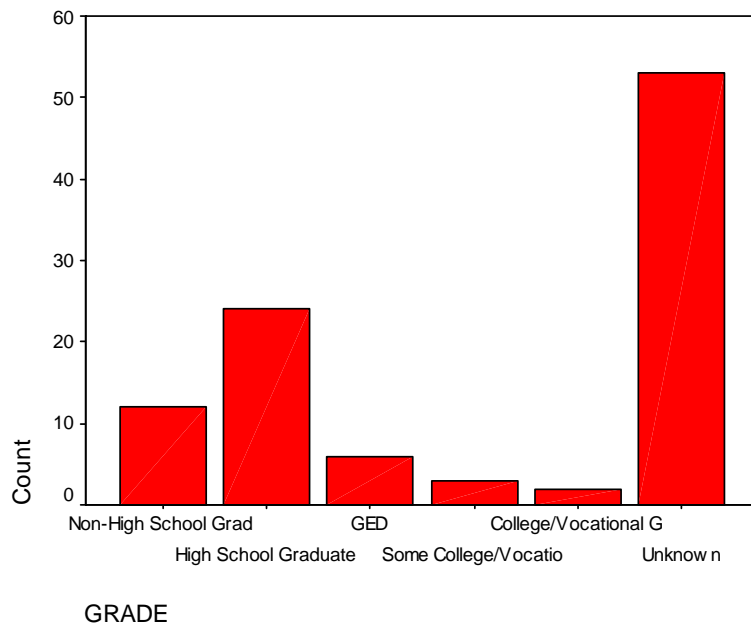
Age of oldest child in the home was 17. Those in the non applicable field are under the age of 1.

Ethnicity



11 families were African American. 87 families were Caucasian. 1 family was Biracial. 1 family was unable to determine.

Education Level of Parent



12 head of households did not complete high school. 24 head of households have high school diplomas. 6 head of households have their GED. 3 head of households have some college or vocational education. 2 head of households graduated from college or vocational schools. 53 head of households were unknown.

Employment/Income

EMPLOY

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Paid Employment	54	54.0	54.0	54.0
	None	41	41.0	41.0	95.0
	Unknown	5	5.0	5.0	100.0
	Total	100	100.0	100.0	

54 of the families have paid employment.

SSI

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	yes	12	12.0	12.0	12.0
	no	82	82.0	82.0	94.0
	unknown	6	6.0	6.0	100.0
	Total	100	100.0	100.0	

12 of the families have Social Security Insurance.

KTAP

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	yes	20	20.0	20.0	20.0
	no	74	74.0	74.0	94.0
	unknown	6	6.0	6.0	100.0
	Total	100	100.0	100.0	

20 of the families receive K-TAP.

SOCSEC

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	yes	5	5.0	5.0	5.0
	no	89	89.0	89.0	94.0
	unknown	6	6.0	6.0	100.0
	Total	100	100.0	100.0	

5 of the families receive social security disability.

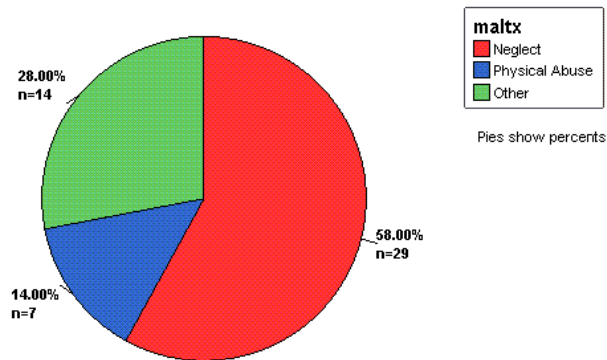
OTHER

		Frequency	Percent	Valid Percent	Cumulativ e Percent
Valid	child support	4	4.0	4.0	4.0
	not applicable	73	73.0	73.0	77.0
	unknown	10	10.0	10.0	87.0
	public assistance	2	2.0	2.0	89.0
	unemployment	2	2.0	2.0	91.0
	food stamps	4	4.0	4.0	95.0
	medical card	2	2.0	2.0	97.0
	wic	1	1.0	1.0	98.0
	retirement	1	1.0	1.0	99.0
	ss survivor	1	1.0	1.0	100.0
	Total	100	100.0	100.0	

27 of the families were unable to determine income.

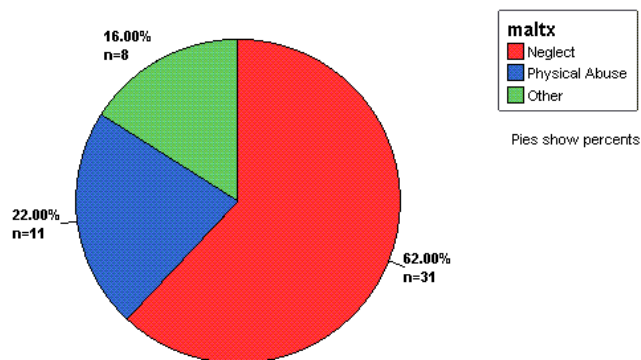
Type of Maltreatment

TAP CASES
TYPE OF MAL-TREATMENT



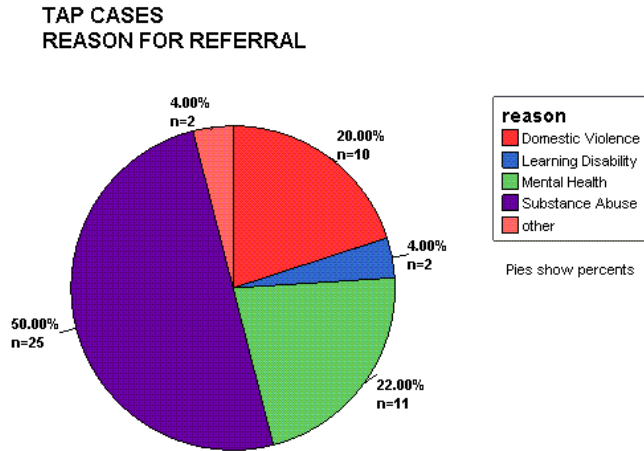
29 cases were opened due to neglect. 7 cases were opened due to physical abuse. 14 cases were opened for other reasons.

NON-TAP CASES
TYPE OF MAL-TREATMENT

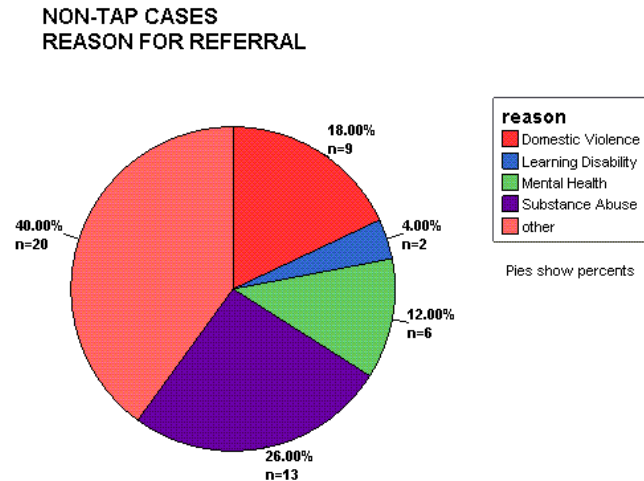


31 cases were opened due to neglect. 11 cases were opened due to physical abuse and 8 cases were opened due to other reasons.

Contributing Factors to Maltreatment



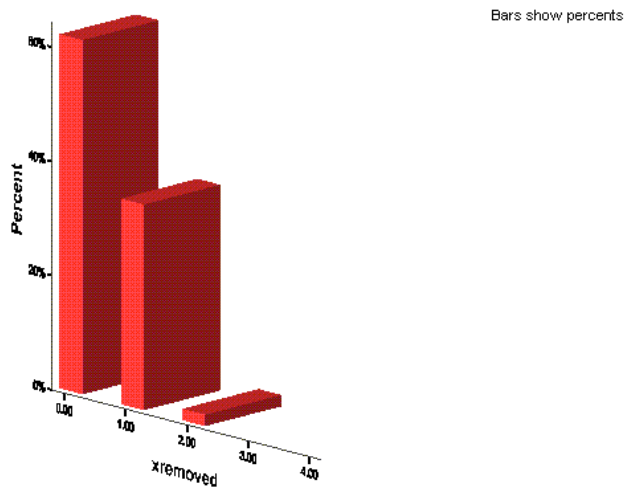
10 cases were referred to TAP for domestic violence. 2 cases were referred to TAP for learning disabilities. 11 cases were referred to TAP for mental health issues. 25 cases were referred to TAP due to substance abuse issues and 2 cases were referred for other reasons.



Domestic violence was a contributing factor in 9 cases. Learning disabilities was a contributing factor in 2 cases. Mental health was a contributing factor in 6 cases. Substance abuse was a contributing factor in 13 cases. Other factors contributed to maltreatment in 20 cases.

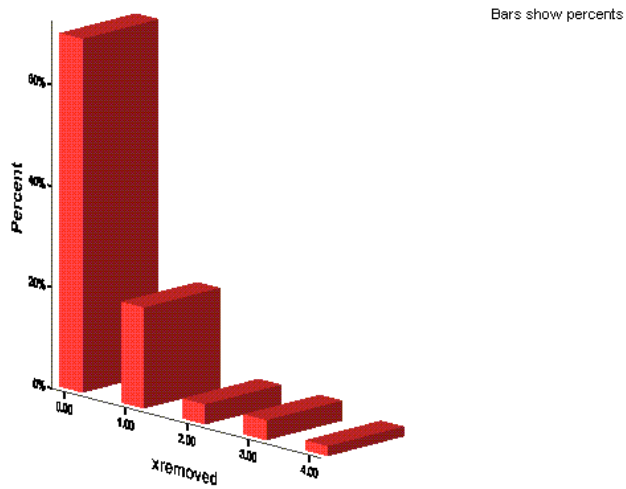
Number of Times Children were Removed from Home

TAP CASES
NUMBER OF TIMES REMOVED FROM THE HOME



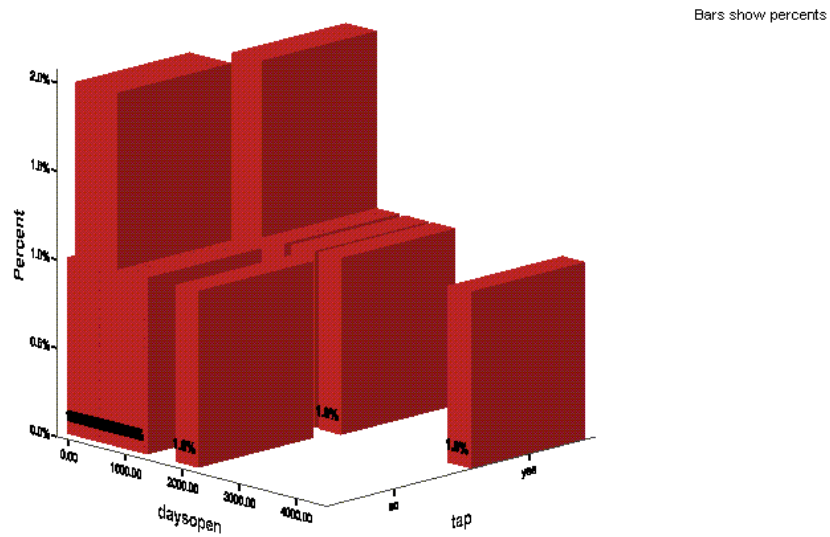
62% percent of families have never had their children removed. 36% of families have had their children removed one time. 2% of families have had their children removed twice.

NON-TAP CASES
NUMBER OF TIMES REMOVED FROM THE HOME



70% of families have never had their children removed. 20% of families have had their children one time. 4% percent of the families have had their children removed twice and 4% of the families have had their children removed three times. 2% of the families have had their children removed 4 times.

Length Case was Open



For those who have TAP the average length of time the case was opened was 611 days.
For those cases who did not have TAP the average length of case was opened 423 days.

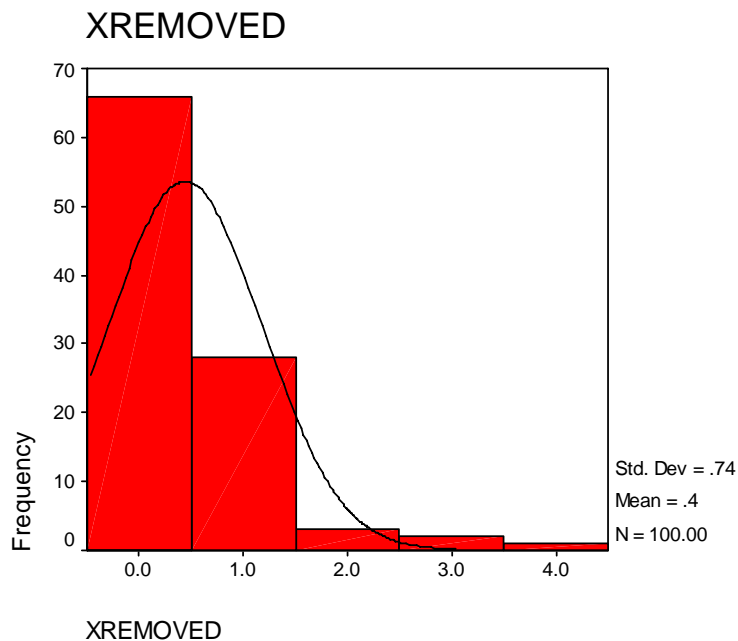
Correlations

Number of Times Removed From Home

Pearson Correlation

		tapyes	tapno	XREMOVED
tapyes	Pearson Correlation	1.000	1.000	.054
	Sig. (2-tailed)	.	.000	.593
	N	100	100	100
tapno	Pearson Correlation	1.000	1.000	.054
	Sig. (2-tailed)	.000	.	.593
	N	100	100	100
XREMOVED	Pearson Correlation	.054	.054	1.000
	Sig. (2-tailed)	.593	.593	.
	N	100	100	100

** Correlation is significant at the 0.01 level (2-tailed).



A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of times children were removed from their parent's home. A weak, non-significant correlation was found ($r(98) = .054$, $p > .05$).

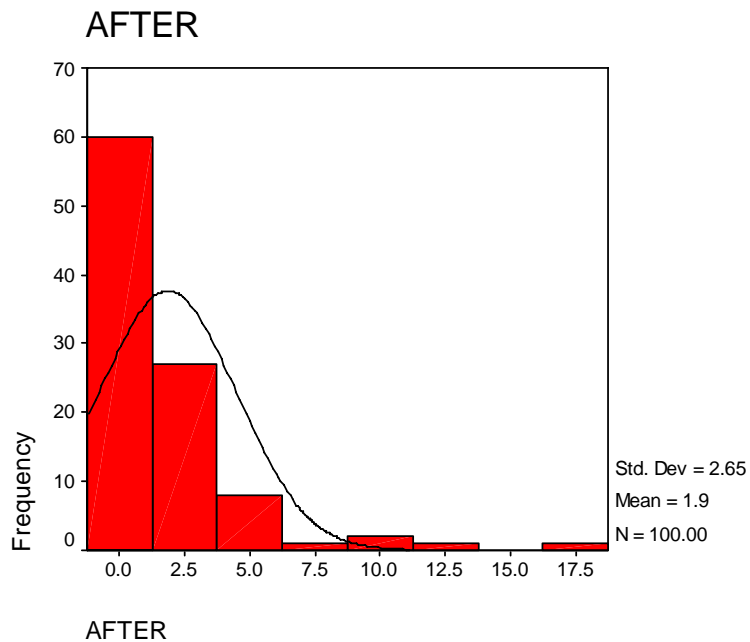
Correlations

Referrals After Ongoing Case

Pearson Correlation

		tapyes	tapno	AFTER
tapyes	Pearson Correlation	1.000	1.000	-.011
	Sig. (2-tailed)	.	.000	.910
	N	100	100	100
tapno	Pearson Correlation	1.000	1.000	-.011
	Sig. (2-tailed)	.000	.	.910
	N	100	100	100
AFTER	Pearson Correlation	-.011	-.011	1.000
	Sig. (2-tailed)	.910	.910	.
	N	100	100	100

** Correlation is significant at the 0.01 level (2-tailed).



A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of referrals after an ongoing case was opened. A weak, negative non-significant correlation was found ($r(98) = -.011$, $p > .05$).

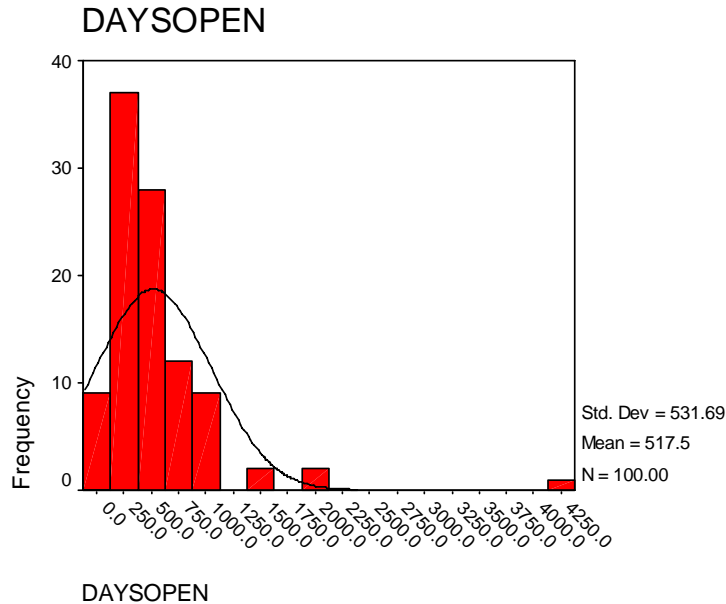
Correlations

Number of Days Case Opened

Pearson Correlation

		tapyes	tapno	DAYSOPEN
tapyes	Pearson Correlation	1.000	1.000	-.179
	Sig. (2-tailed)	.	.000	.076
	N	100	100	100
tapno	Pearson Correlation	1.000	1.000	-.179
	Sig. (2-tailed)	.000	.	.076
	N	100	100	100
DAYSOPEN	Pearson Correlation	-.179	-.179	1.000
	Sig. (2-tailed)	.076	.076	.
	N	100	100	100

** Correlation is significant at the 0.01 level (2-tailed).



A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of days a case was open. A weak, negative correlation was found ($r(98) = -.179$, $p < .05$), indicating a significant negative relationship between the variables.

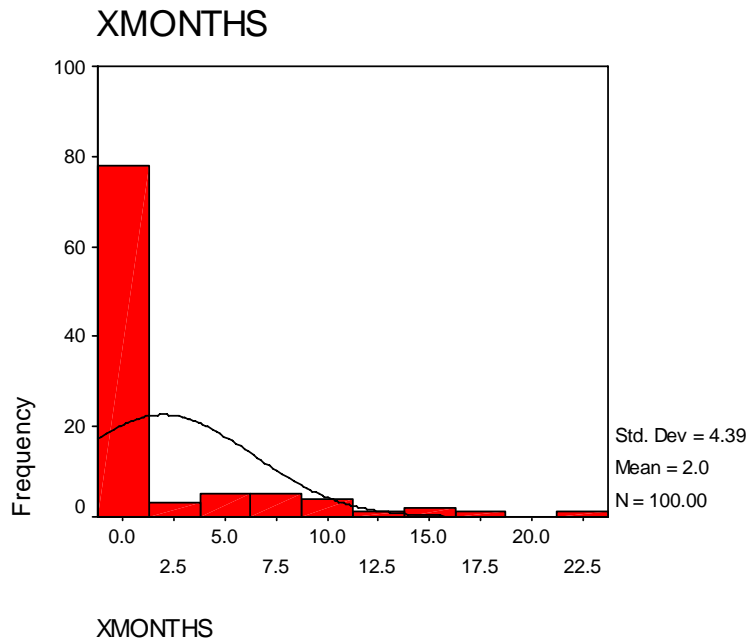
Correlations

Number of Months Child Out of Parent's Home

Pearson Correlation

		tapyes	tapno	XMONTHS
tapyes	Pearson Correlation	1.000	1.000	-.023
	Sig. (2-tailed)	.	.000	.821
	N	100	100	100
tapno	Pearson Correlation	1.000	1.000	-.023
	Sig. (2-tailed)	.000	.	.821
	N	100	100	100
XMONTHS	Pearson Correlation	-.023	-.023	1.000
	Sig. (2-tailed)	.821	.821	.
	N	100	100	100

** Correlation is significant at the 0.01 level (2-tailed).



A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of months children spent in out of home care. A weak, non-significant correlation was found ($r(98) = -.023$, $p > .05$).

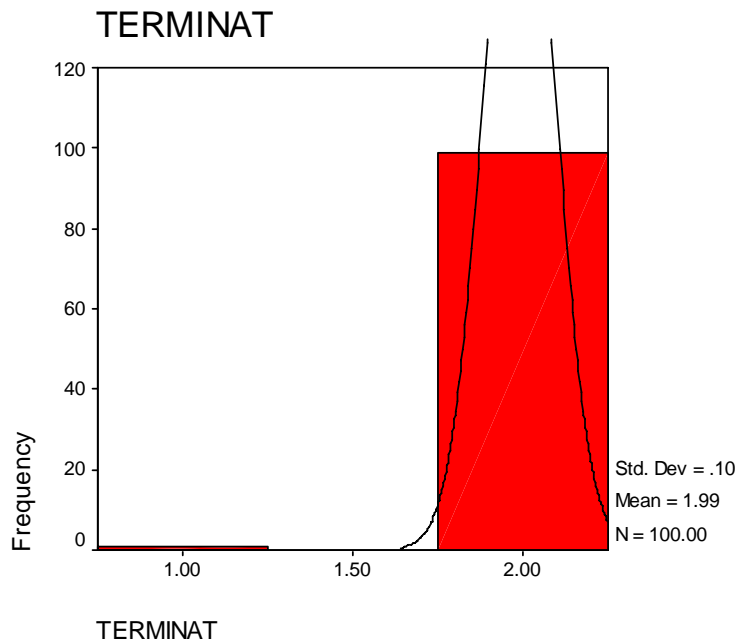
Correlations

Termination of Parental Rights

Pearson Correlation

		tapyes	tapno	TERMINAT
tapyes	Pearson Correlation	1.000	1.000	.101
	Sig. (2-tailed)	.	.000	.320
	N	100	100	100
tapno	Pearson Correlation	1.000	1.000	.101
	Sig. (2-tailed)	.000	.	.320
	N	100	100	100
TERMINAT	Pearson Correlation	.101	.101	1.000
	Sig. (2-tailed)	.320	.320	.
	N	100	100	100

** Correlation is significant at the 0.01 level (2-tailed).



A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the termination of parental rights in a case. A weak, non-significant correlation was found ($r(98) = .101$, $p > .05$).

The Effect of the Targeted Assessment Program on Child Welfare Outcomes

Michelle Baize

Tonya Blandford

Lisa Bosley

Brandon Harley

Kimberly Wright Osborne

Helen Martin Young

University of Louisville

INTRODUCTION

Through a contract with the Kentucky Cabinet for Families and Children, the University of Kentucky Institute on Women and Substance Abuse, a Division of the Center on Drug and Alcohol Research, has developed the Targeted Assessment Program (TAP), to identify and address multiple barriers to family self-sufficiency and safety among Department for Community Based Services (DCBS) clients.

INTRODUCTION

The purpose of this research is to determine if clients who receive TAP services have their cases closed sooner and have less referral recidivism than those clients who did not receive TAP.

INTRODUCTION

Data will be examined from case files of clients who were recipients of TANF through DCBS, had an open case with the Protection and Permanency branch of DCBS and were accessing TAP services. Data will be examined from an equal number of non-TAP recipient case files.

INTRODUCTION

Data examined will include demographics as well as qualitative and quantitative information that will either substantiate or refute the effectiveness of the TAP program in decreasing the amount of time the client case is active with DCBS and referral recidivism. Identification of strengths and weaknesses of TAP will increase the effectiveness of the program as it continues to develop and address the many needs of the hard to serve population and assist in the direction needed for future research.

LITERATURE REVIEW

Lack of identification or improper identification of “hard to serve clients” is of considerable consequence, not only to the individuals in need of service, but also to the states that administer TANF grants. Improper identification and assessment of vulnerable clients could lead to an increase in social problems such as homelessness, and an increase in the number of families becoming involved with child protective services due to issues of child neglect (Postmus, 2004; Taylor and Barusch, 2004; Romero and Chavkin, 2000).

LITERATURE REVIEW

Research suggests that the needs of “hard to serve” recipients are best met when full-time, on-site assessors are co-located within the welfare department. This approach has resulted in an increase in referrals for assessment and treatment, and has also increased the participation rate of “hard to serve” recipients (Jacobi, Hendrickson, and Wallace, 2002).

LITERATURE REVIEW

Although the statistics vary, the research cited from public reports as well as independent research reveals there is a significant connection between parental substance abuse and child maltreatment (Chaffin et al. 1996).

LITERATURE REVIEW

Because substance abuse has permeated families involved with child protective service (CPS) agencies so rapidly, the training of child welfare workers in this area has not kept pace with the demand. This issue is made even more difficult by the natural tendency of most substance abusers to minimize or even conceal alcohol and drug problems (Gustavsson, 1991; Ritner & Dozier, 2000; Thompson, 1990).

LITERATURE REVIEW

Research has linked mild learning disabilities with specific mental health diagnoses including, depression, anxiety disorders, psychosis, compulsions, eating disorders, and substance abuse (Hatton, 2002). Often, these lead diagnoses disguise the presence of learning disabilities and its correlation with acts of maltreatment in many homes (James, 2004).

LITERATURE REVIEW

The health and well-being of parents and children are intimately intertwined. Research indicates that mental illness not only places children at risk for developing psychosocial problems, but children's needs and responses for not having their needs met adds burden to the parents (Nicholson & Clayfield, 2004).

LITERATURE REVIEW

According to Pearl Schmier (2004) the following consequences of children living with a parent with active mental health illnesses must be considered: "lack of appropriate supervision, questionable judgment regarding appropriate alternative caregivers and the risks of abuse inherent in that, parentification of children, a skewed world view passed on to the children, inconsistent parenting, inconsistency in the parent's personality, the needs of the children for family, safety, stability, and permanency." Social service workers must be mindful of these possible consequences, think of the best interest of the child, and rapidly link the parent to service providers that could be most beneficial to their certain illness.

LITERATURE REVIEW

Victims of domestic violence have the highest rates of child abuse. Victims who were subjected to minor violence had more than double the rates of physical assaults on children than did women not experiencing that kind of abuse. The victim may be attempting to make the children behave in an attempt to avoid getting abused herself. The perpetrator might also force the victim to discipline the child in an abusive manner (Jones, Gross and Becker, 2002).

LITERATURE REVIEW

Co-housing treatment providers and those who administer welfare assistance, has led to a great understanding of the problems encountered by the "hard to serve". Furthermore, it has promoted a collaborative effort between treatment providers and child welfare caseworkers to move clients to self-sufficiency (Jacobi et al. 2002).

QUANTITATIVE QUESTION

What is the effect of the Targeted Assessment Program on Child Protective Services Cases?

QUANTITATIVE DESIGN

An exploratory design was used in this study. Data was collected by assessing information in a chart review.

QUANTITATIVE SAMPLE

- 100 cases randomly selected
- 50 cases from Henderson and Daviess Counties were selected
- 25 cases that had received TAP services from both counties
- 25 cases that had NOT received TAP services from both counties

VARIABLES

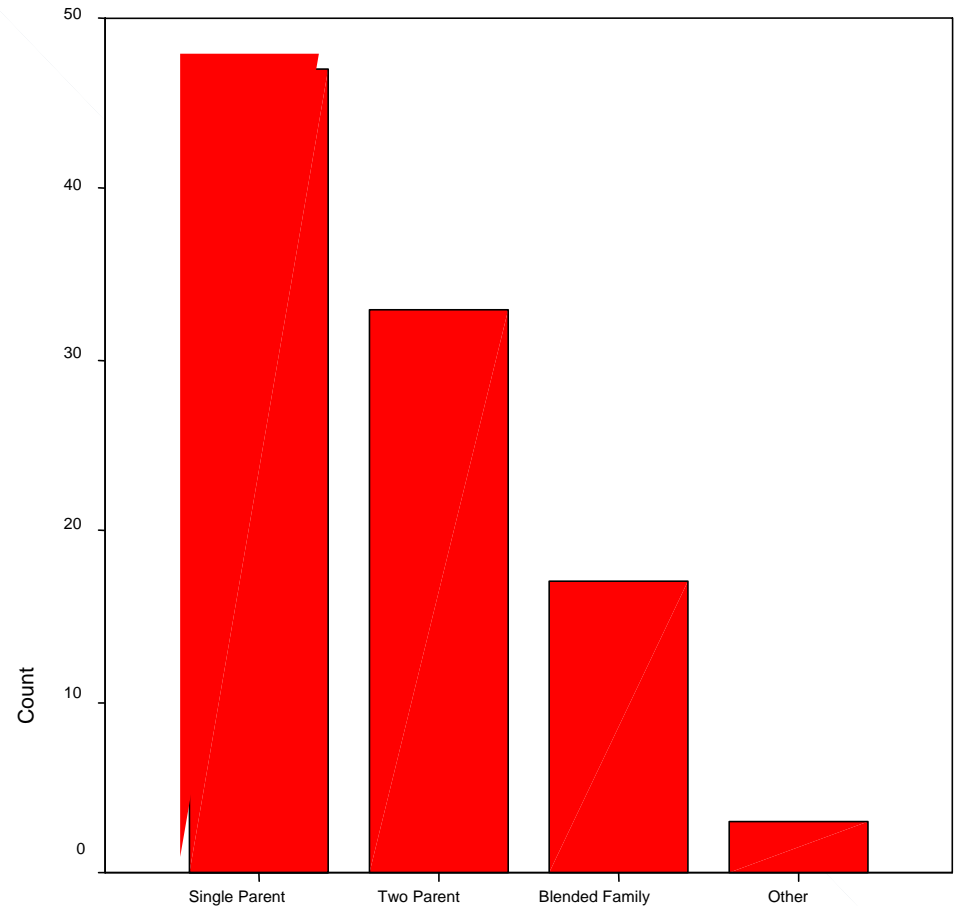
TAP VS NON-TAP

- Demographics
- Type of Maltreatment
- Reason for referral
- Number of times removed from the home
- Number of days cases opened

Quantitative Analysis

Type of Household

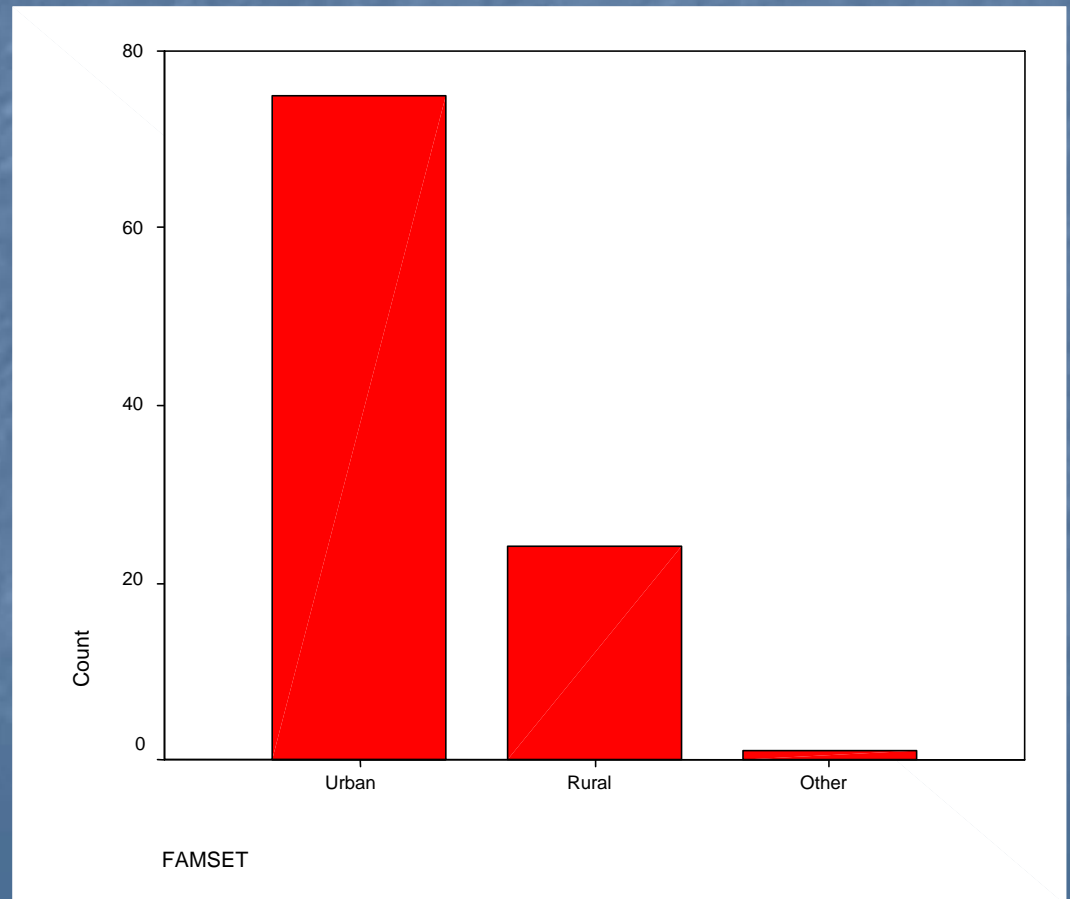
- 47 single parent families (non-gender specified)
- 33 two-parent families defined as a father and mother
- 17 blended families
- 3 other-type households were included in the study.



Quantitative Analysis

Family Setting

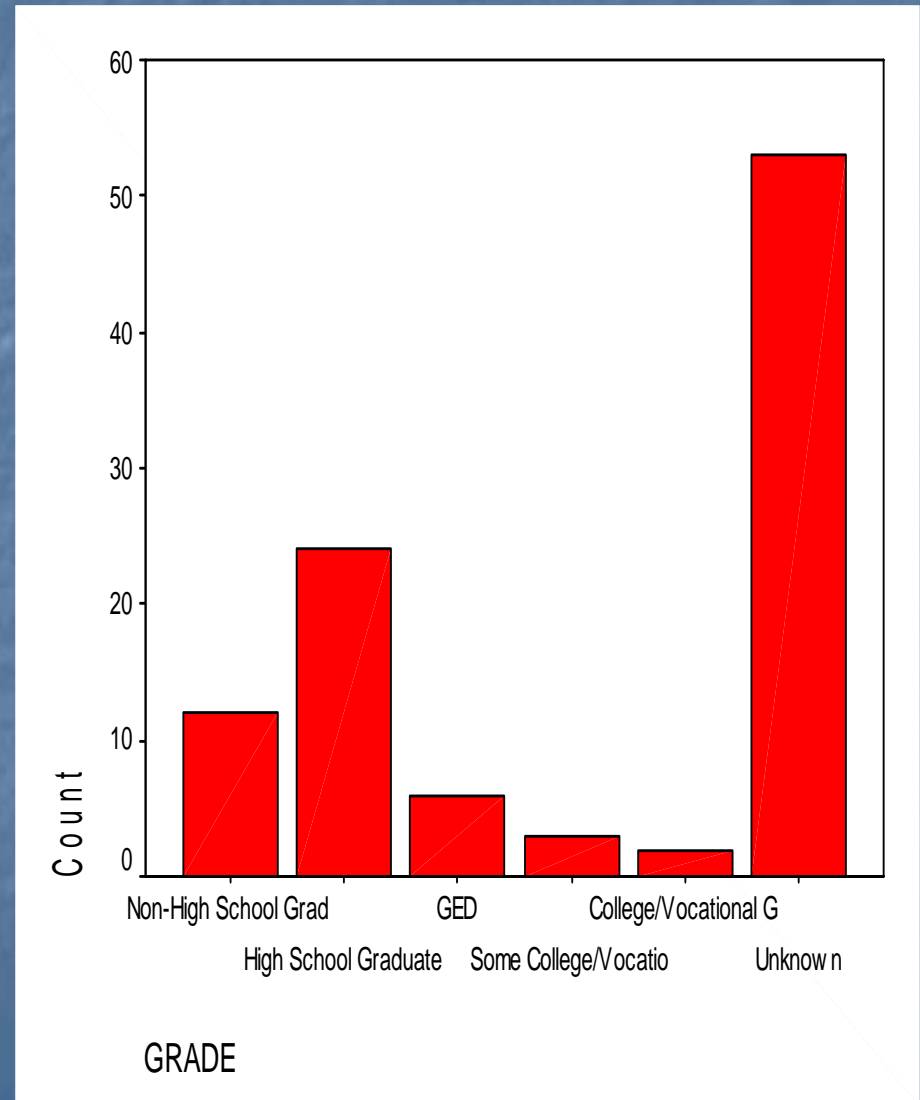
- 75 families live in an urban setting, defined as living within the city limits of Owensboro or Henderson Kentucky.
- 24 families live in a rural setting, defined as living outside of Owensboro or Henderson city limits.
- 1 family lived in a setting that was unable to be determined.



QUANTITATIVE ANALYSIS

Education Level of Parent

- 12 head of households did not complete high school
- 24 head of households have high school diplomas
- 6 head of households have their GED
- 3 head of households have some college or vocational education
- 2 head of households graduated from college or vocational schools
- 53 head of households were unknown

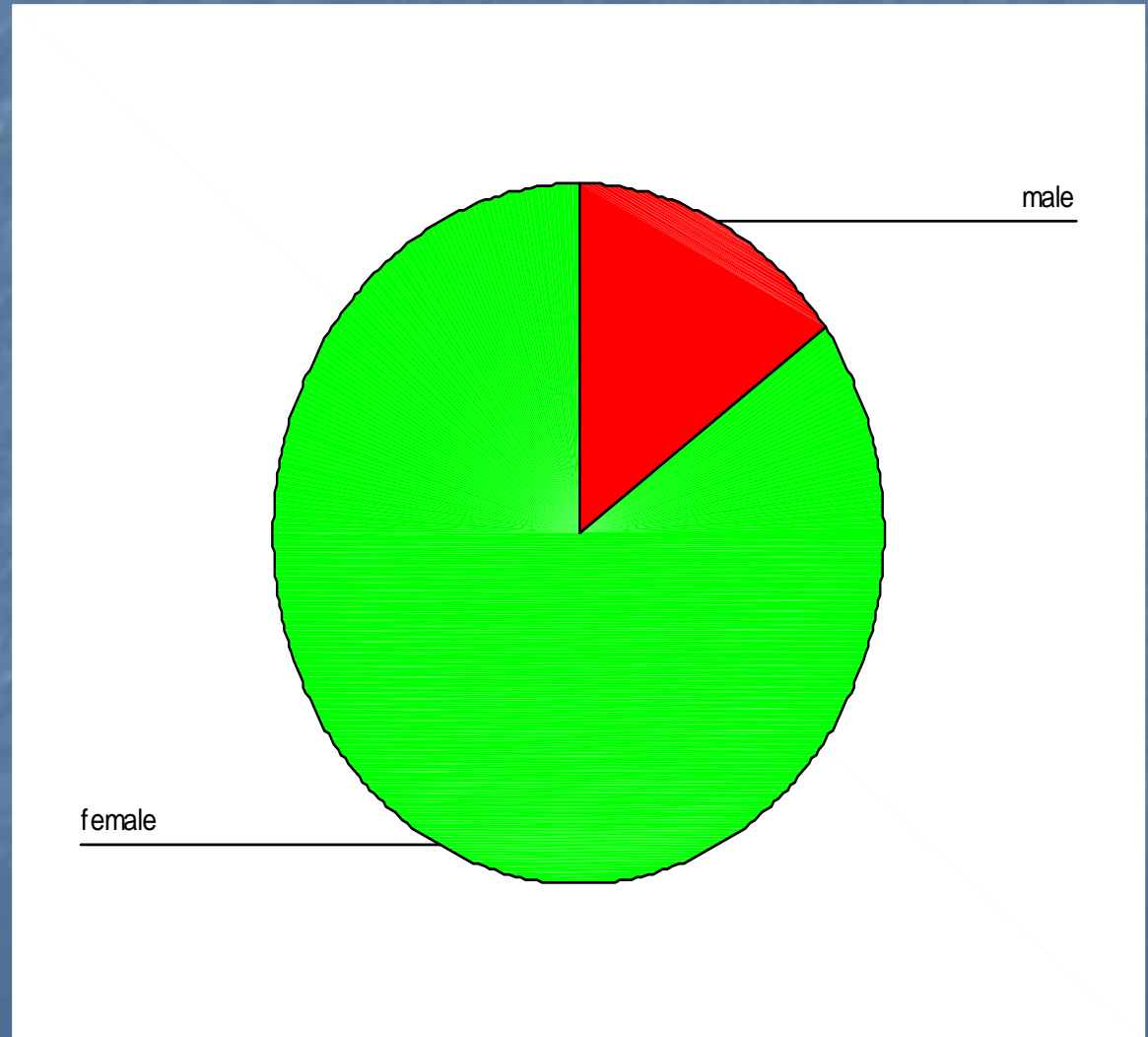


QUANTITATIVE ANALYSIS

Gender

85 head of households
were female

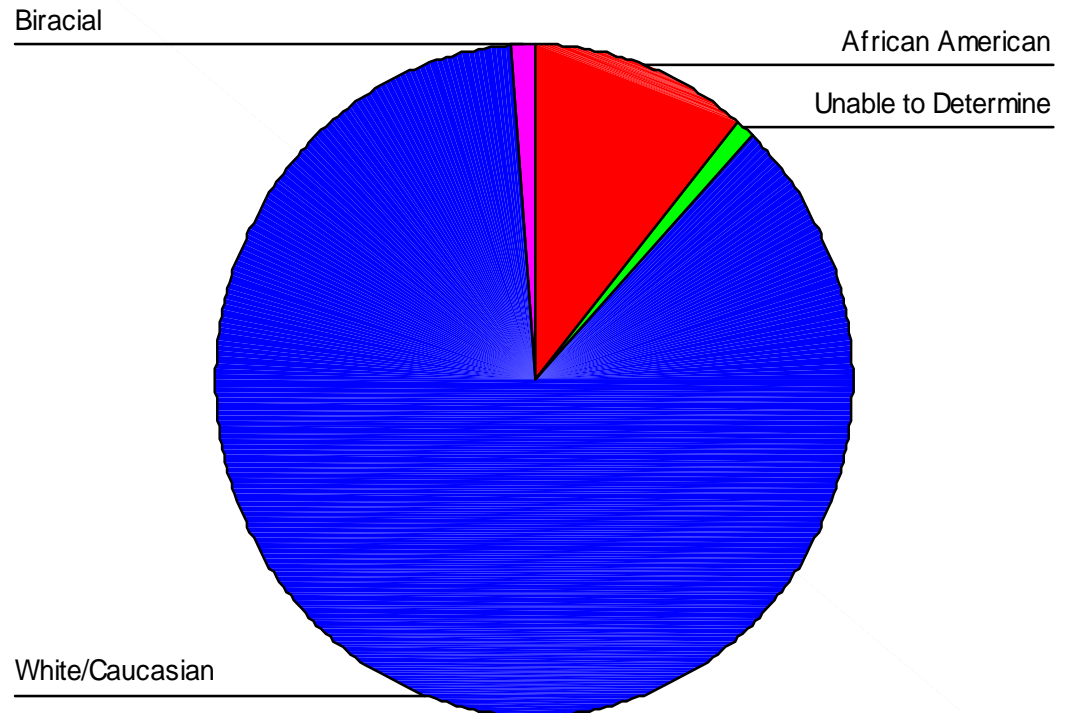
15 head of households
were male



QUANTITATIVE ANALYSIS

Ethnicity

- 11 families were African American
- 87 families were Caucasian
- 1 family was Biracial
- 1 family was unable to determine

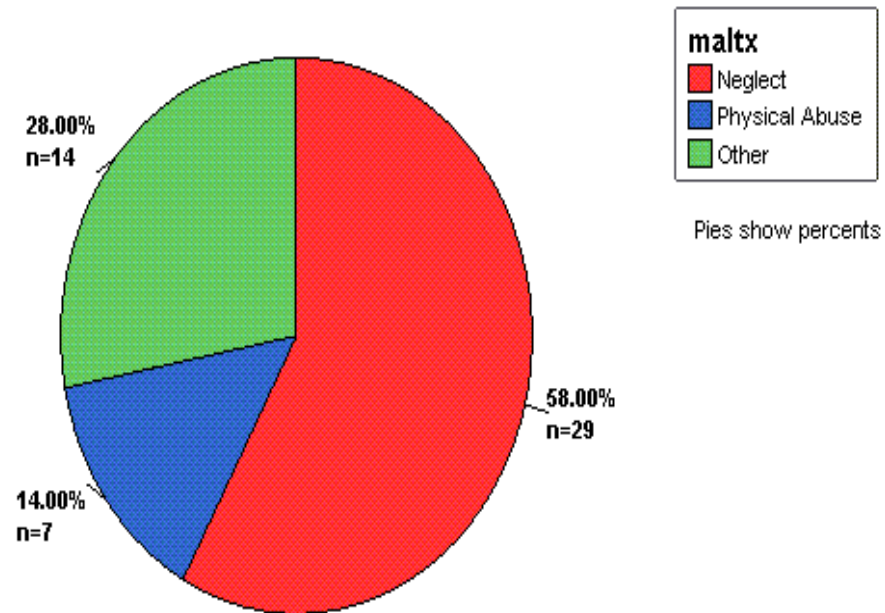


QUANTITATIVE ANALYSIS

TAP Cases Type of Maltreatment

- 29 cases were opened due to neglect
- 7 cases were opened due to physical abuse
- 14 cases were opened for other reasons

TAP CASES
TYPE OF MAL-TREATMENT

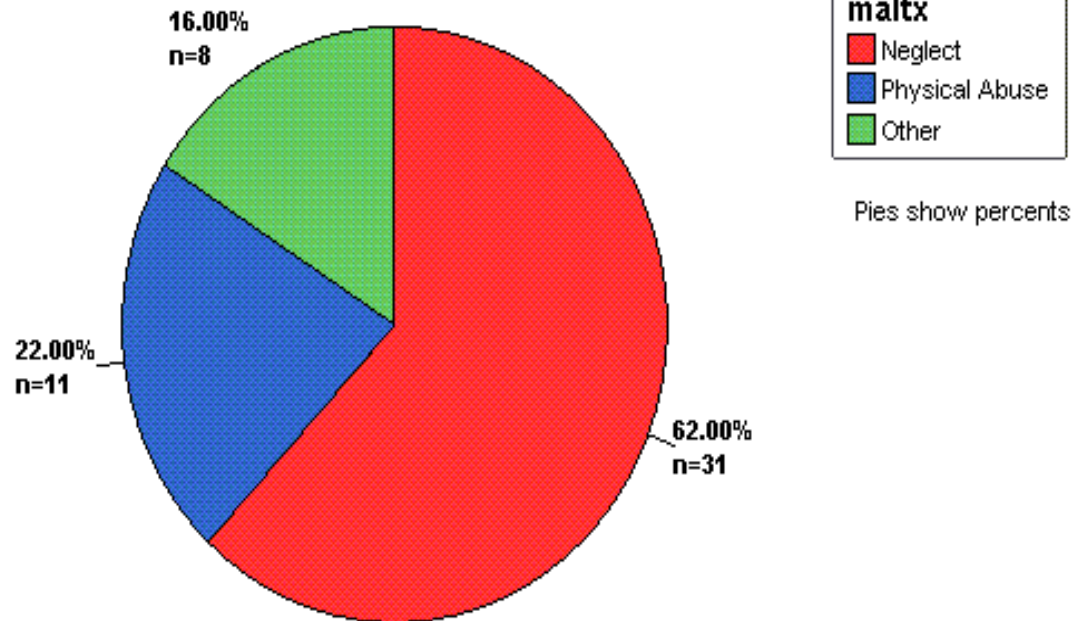


QUANTITATIVE ANALYSIS

Type of Maltreatment in Non-TAP Cases

- 31 cases were opened due to neglect
- 11 cases were opened due to physical abuse
- 8 cases were opened due to other reasons

NON-TAP CASES
TYPE OF MAL-TREATMENT

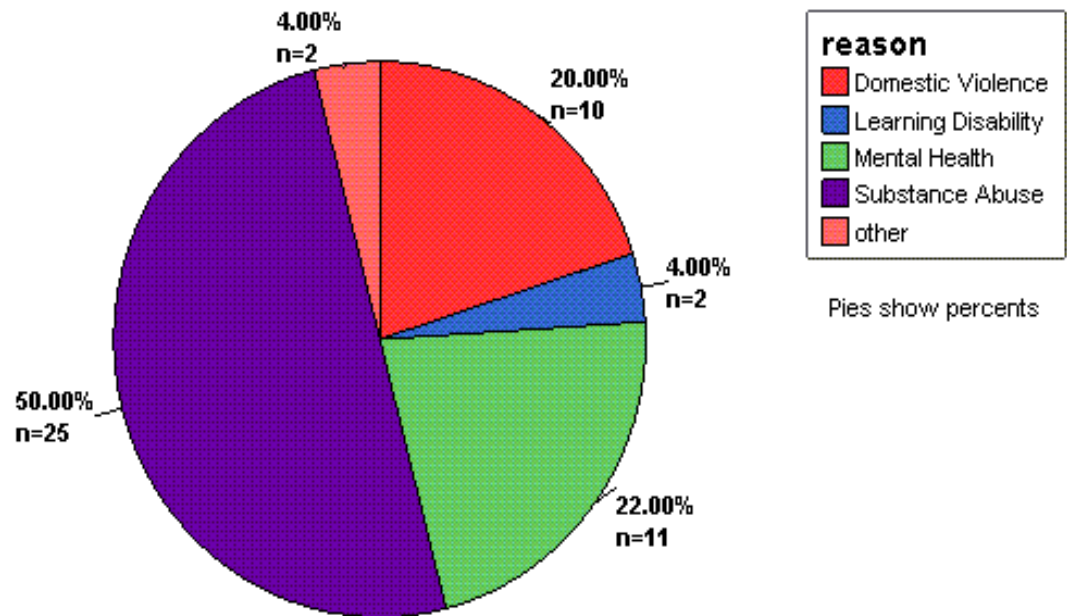


QUANTITATIVE ANALYSIS

Contributing Factors to Maltreatment

- 10 cases domestic violence
- 2 cases learning disabilities
- 11 cases mental health issues
- 25 cases substance abuse issues
- 2 cases other reasons

TAP CASES
REASON FOR REFERRAL

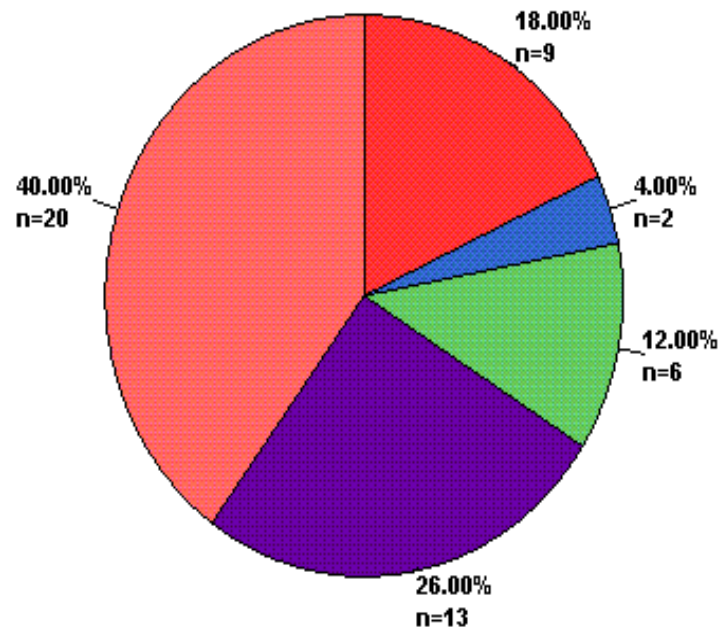


QUANTITATIVE ANALYSIS

Contributing factors to maltreatment in non-TAP cases

- 9 cases domestic violence
- 2 cases learning disabilities
- 6 cases mental health
- 13 cases substance abuse

NON-TAP CASES
REASON FOR REFERRAL

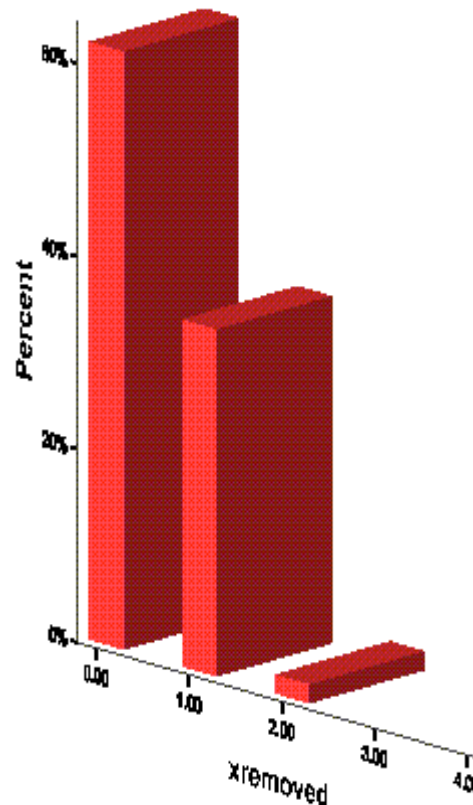


QUANTITATIVE ANALYSIS

Number of Times Children were Removed from Home

- 62% percent of families have never had their children removed
- 36% of families have had their children removed one time
- 2% of families have had their children removed twice

TAP CASES
NUMBER OF TIMES REMOVED FROM THE HOME

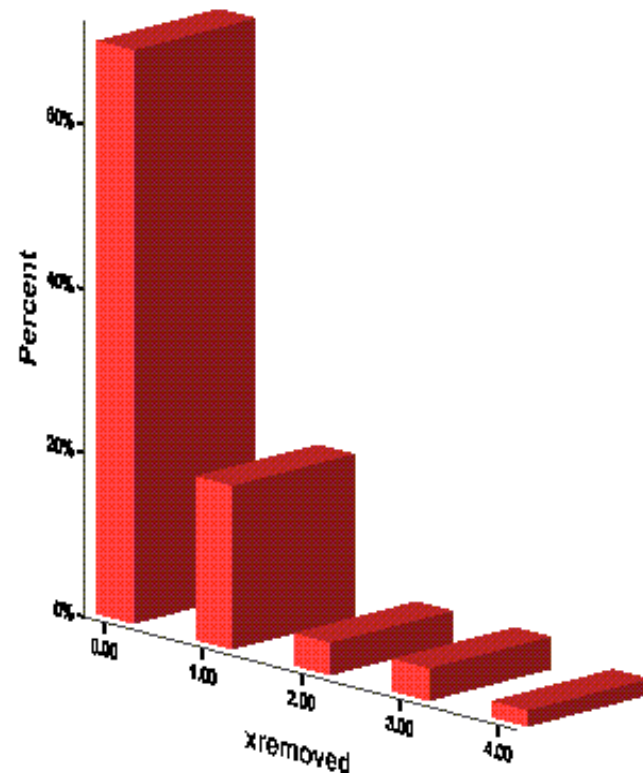


QUANTITATIVE ANALYSIS

Non-TAP Cases Number of Times Children were Removed from Home

- 70% of families have never had their children removed
- 20% of families have had their children one time. 4% percent of the families have had their children removed twice
- 4% of the families have had their children removed three times
- 2% of the families have had their children removed 4 times

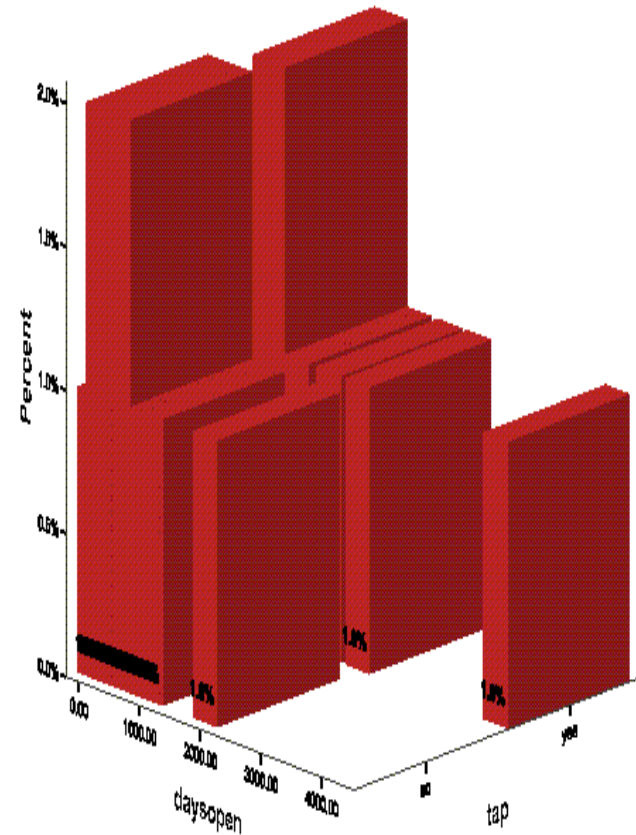
NON-TAP CASES
NUMBER OF TIMES REMOVED FROM THE HOME



QUANTITATIVE ANALYSIS

Length Case was Open

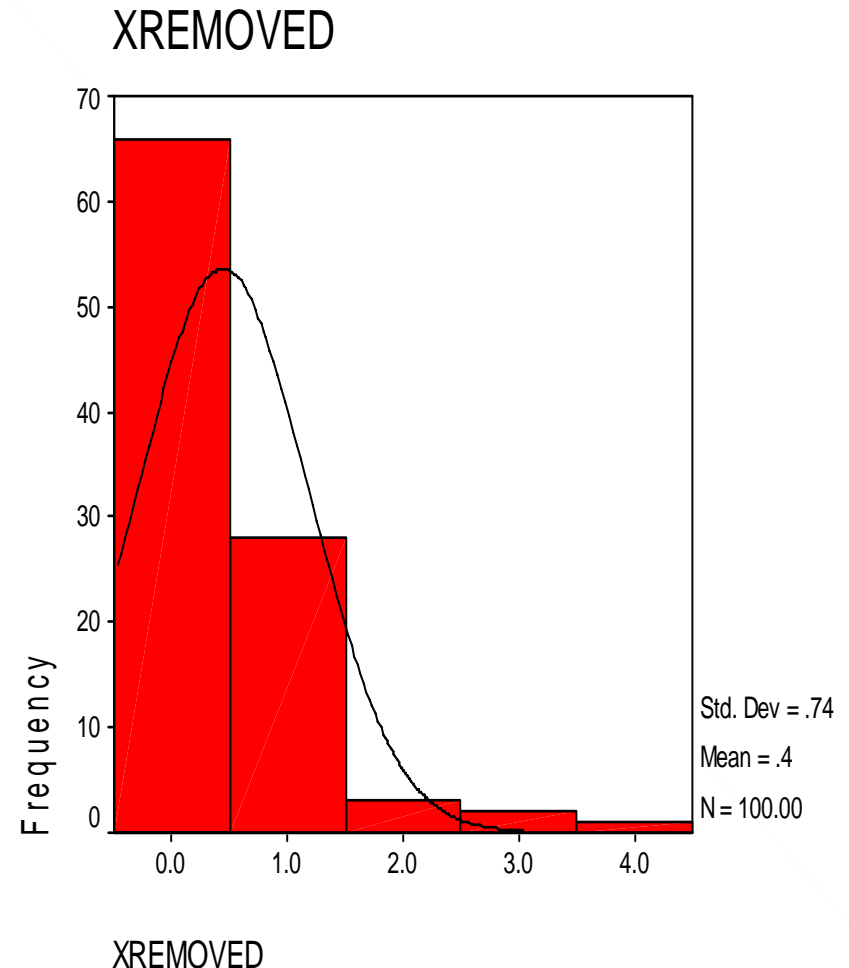
- For those who have TAP the average length of time the case was opened was 611 days
- For those cases who did not have TAP the average length of case was opened 423 days.



QUANTITATIVE ANALYSIS

Number of Times Removed

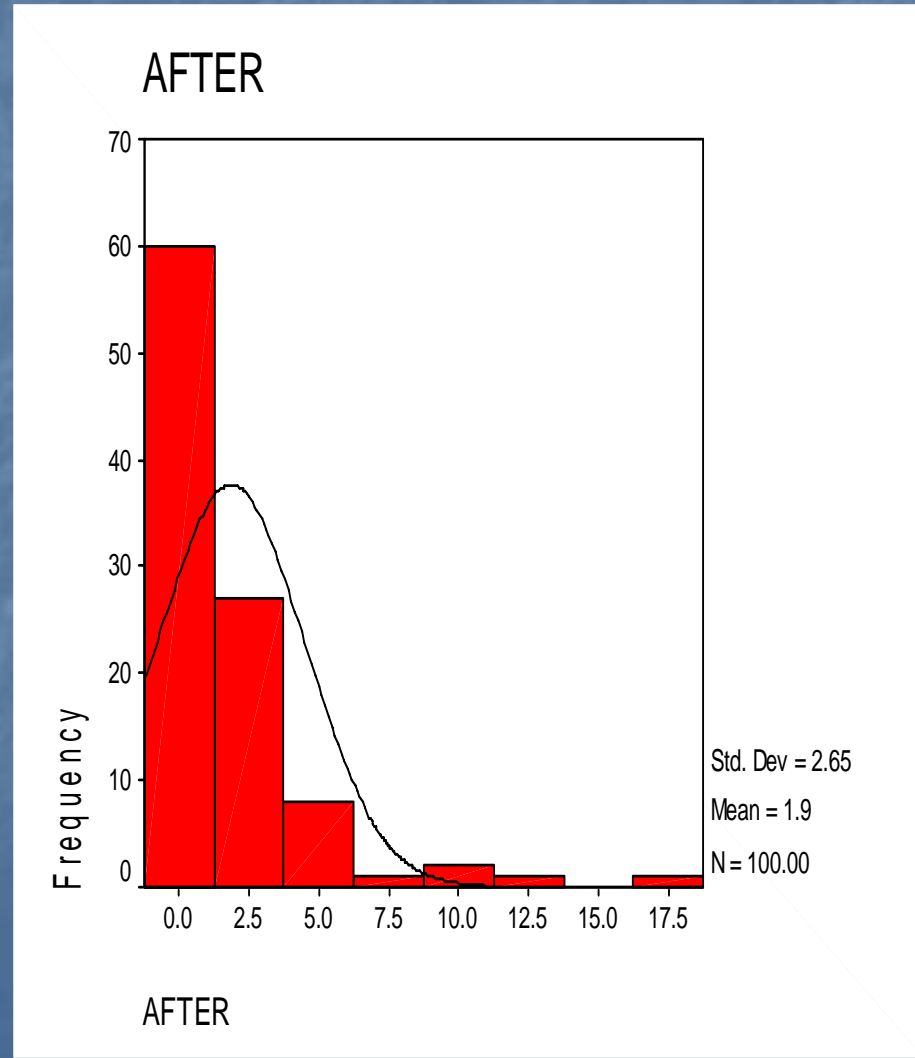
A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of times children were removed from their parent's home. A weak, non-significant correlation was found ($r(98) = .054$, $p > .05$)



QUANTITATIVE ANALYSIS

Number of Referrals After TAP Involvement

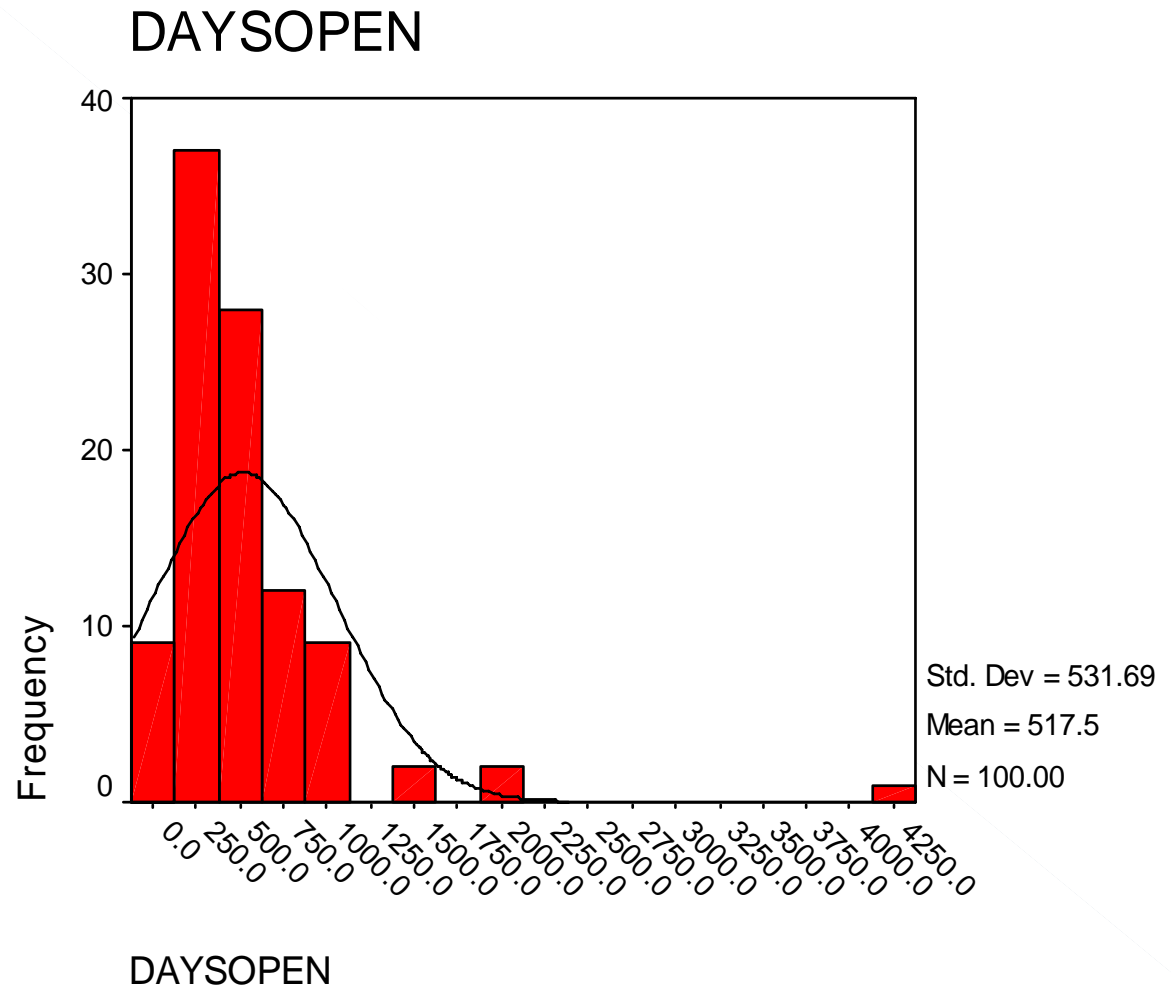
A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of referrals after an ongoing case was opened. A weak, negative non-significant correlation was found ($r(98) = -.011$, $p > .05$)



QUANTITATIVE ANALYSIS

Number of Days Opened and TAP Involvement

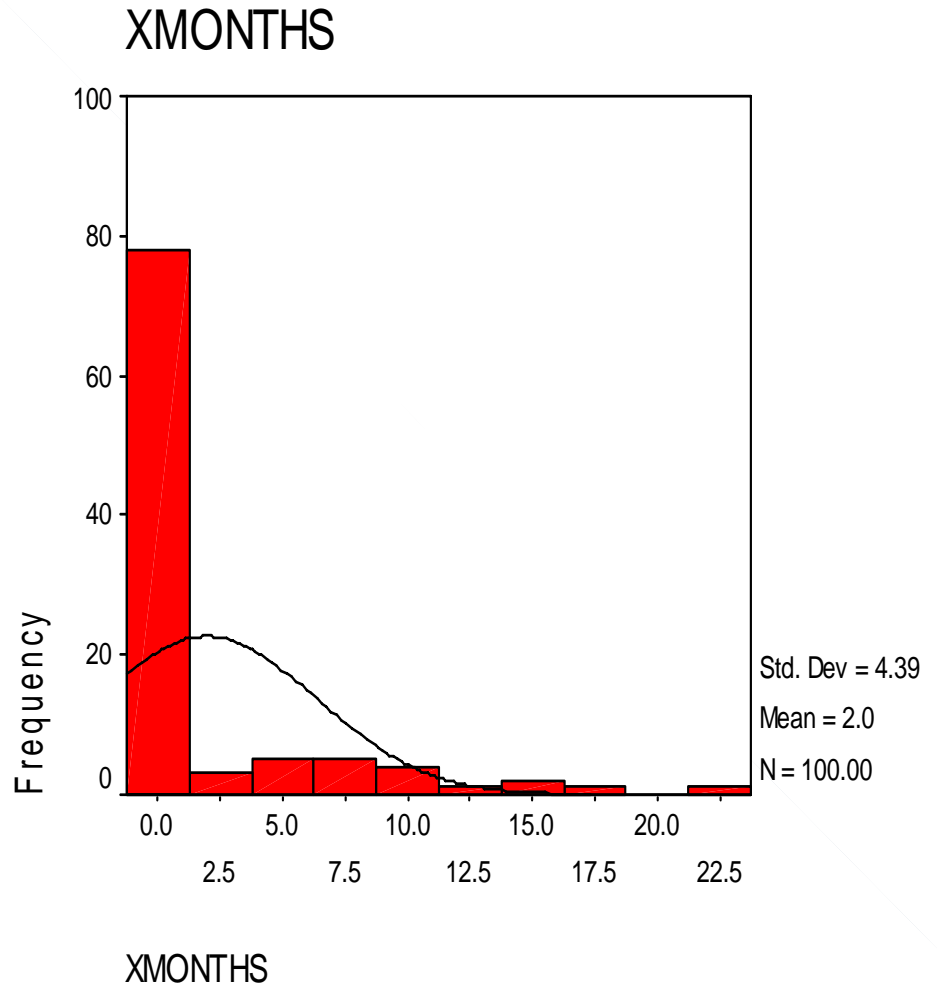
A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of days a case was open. A weak, negative correlation was found ($r(98) = -.179$, $p < .05$), indicating a significant negative relationship between the variables



QUANTITATIVE ANALYSIS

Number of Months in OOHC and TAP Involvement

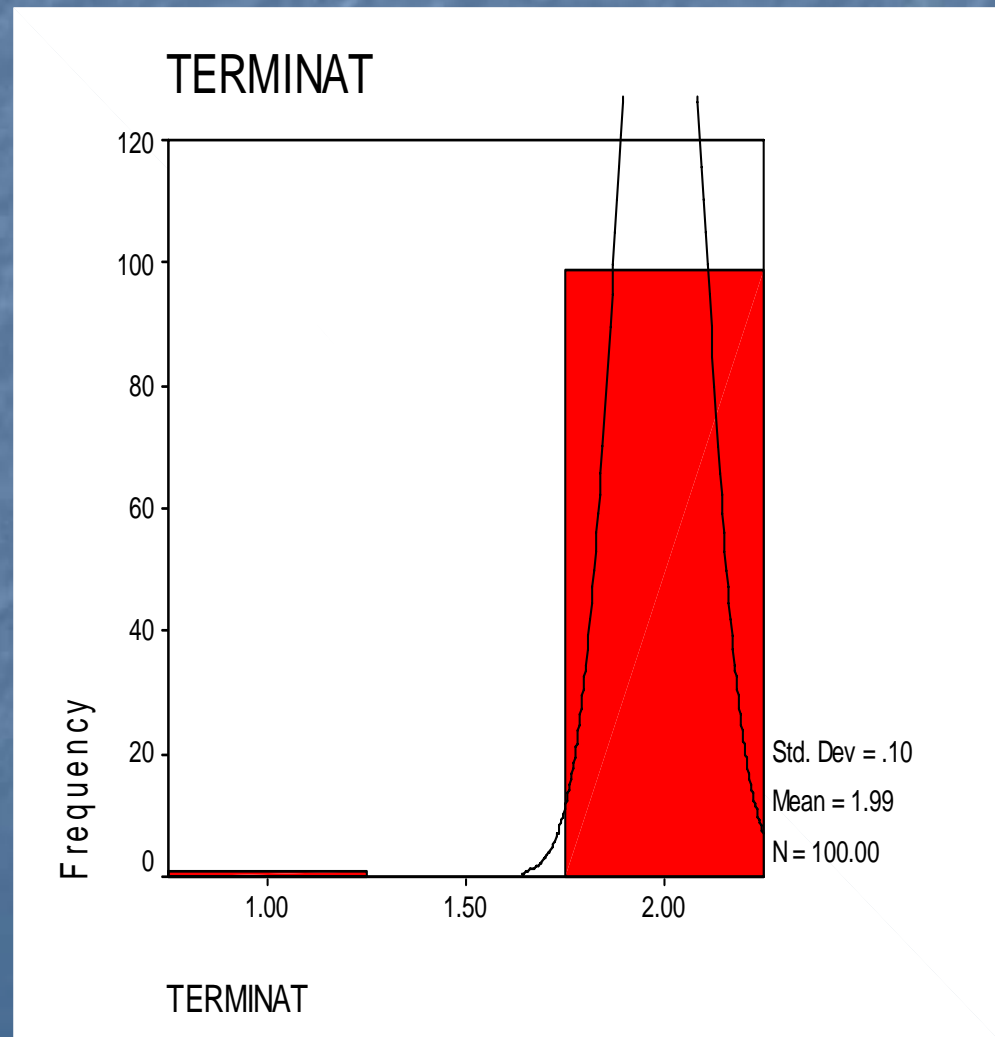
A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the number of months children spent in out of home care. A weak, non-significant correlation was found ($r(98) = -.023$, $p > .05$)



QUANTITATIVE ANALYSIS

Termination of Parental Rights and TAP

A Pearson correlation coefficient was calculated for the relationship between TAP involvement and the termination of parental rights in a case. A weak, non-significant correlation was found ($r(98) = .101$, $p > .05$)



QUALITATIVE QUESTION

What characteristics of TAP lead to successful outcomes in Child Protective Services?

QUALITATIVE DESIGN AND DATA COLLECTION

- Based on Grounded Theory Methodology
- Minimal structured interviews were conducted
- 4 DCBS social workers and 2 TAP specialists participated in the interviews

QUALITATIVE ANALYSIS

- Constant comparison of data
- Line by line coding
- Identified dominant themes

THEMES AND QUOTES

- "I can't imagine going back to the time when we didn't have TAP services."
- "TAP is a great asset to our agency."
- "TAP is like a one stop shop for services."
- "TAP program becomes one of the client's biggest support system because the rapport is so strong."
- "The most beneficial thing about TAP is that it fills a gap between services."

THEMES AND QUOTES

"Our families already face enough stress in their everyday lives. Requiring them to complete an assessment with an outside agency where they will likely be charged for the service is just placing one more burden on them. Reducing stress and financial concerns for a family is a factor in reducing repeat maltreatment."

THEMES AND QUOTES

"Overall, I believe that TAP cases are closed more quickly. Once the TAP assessment is completed a family can be referred for the services appropriate to their specific needs. Engaging the family in the treatment process as quickly as possible assists the family in meeting the goals and objectives of their case plan".

QUALITATIVE FINDINGS

- TAP is beneficial
- Serves as a support system for clients
- Asset to DCBS agency
- Fills a gap between services
- "TAP is like a one stop shop for services."
- "Could not imagine DCBS without TAP."

LIMITATIONS

- Incomplete documentation in TWIST (The Worker Information System) - particularly regarding income and education
- Inability to access Targeted Assessment Program records due to privacy laws
- Documentation regarding actual TAP services in cases were incomplete
- Delayed DCBS IRB approval limited ability to gather information

CONCLUSION

- Although the quantitative portion of the research yielded confounding results, the qualitative portion of the research revealed positive themes.
- The quantitative results may be attributed to the fact that TAP is often utilized in high-risk, tenuous cases, therefore they will need longer and intensive services.

FUTURE RESEARCH

- Geared toward which areas TAP services benefit clients most: Substance Abuse, Mental Health, Domestic Violence, or Learning Disabilities
- Service comparison between TANF/Family Support recipients and Child Protection clients